

VOLUNTEERING AND SOCIAL CAPITAL: A CASE STUDY OF OLDER
HOSPITAL VOLUNTEERS IN SOUTHERN ONTARIO

Saranjah Subramaniam, BSc (Hons.)

Submitted in partial fulfillment of the requirements for the degree of
Master of Arts in Applied Health Sciences
(Community Health)

Faculty of Applied Health Sciences, Brock University
St. Catharines, Ontario, Canada

© February 2016

Dedication

I want to dedicate this thesis first and foremost to my loving husband, Sathya Amirthavasagam. You have been there for me every step of the way, from the moment I first started this program, to the day I defended my thesis. Thank you for being who you are. I love you.

I want to dedicate this thesis to my family: my mother, my father, and my brother. Without your constant encouragement and support to continue my education in this field, I would not be here today. Thank you and I love all of you.

Abstract

Volunteering as a form of social activity can facilitate older adults' active aging through community engagement. The purpose of this qualitative case study was to understand the views on older adults' volunteerism in a community hospital network in Southern Ontario. Utilizing in-depth interviews with 10 older volunteers (over the age of 65), document analysis, and a key informant interview, I explored their experiences of volunteering and social capital development at six hospitals in the network. Data analyses included open and axial coding, and conceptualization of the themes. Four major themes emerged from the data: reasons to volunteer, management's influence, negative experiences of volunteering, and connections with others. The findings of this research emphasized older volunteers' strong commitment and enthusiasm to support the hospital in their own communities, the power of volunteering to enhance the development of bonding, bridging, and linking social capital, and the influence of two major contextual factors (i.e. the Auxiliary Factor and the Change Factor) to facilitate or hinder older volunteers' social capital development in the hospitals. Future research directions should focus on further unpacking the different degrees to which each type of social capital is developed, placing emphasis on the benefits of social capital development for volunteers in healthcare settings. The implications for practice include the targeted recruitment of older adults as healthcare volunteers while creating volunteer positions and environments in which they can develop social capital with their peer volunteers, hospital staff, patients, and people in surrounding communities. To sustain their existing dedicated long-term volunteers, in particular their Auxiliary groups, the community hospital network can enhance facilitating factors such as the Auxiliary Factor while mitigating the negative

effects of the Change Factor. By developing social capital through volunteering in their own communities, older adults can engage in active aging, while participating in the development of an age-friendly community.

Keywords: older adults, volunteers, hospitals, social capital, active aging

Acknowledgments

I want to thank my supervisor for her support during my Masters. Dr. Miya Narushima always encouraged me to do my best and to keep persevering in exploring, questioning, and conducting research. It is because of her dedication and belief in me that I am here today.

I want to thank my committee members Dr. Madelyn Law and Dr. Paula Gardner for their advice and encouragement on my thesis, as well as always supporting any endeavor I undertook in learning community health promotion and teaching. I want to also thank my external examiner Dr. Susan Arai for encouraging me to continue my studies and further my knowledge in the realm of social capital and gerontology.

Lastly, I want to thank all of the older volunteers and key informants in this Southern Ontario community hospital network. Their time, interest, and wonderful stories gave me the opportunity to conduct this meaningful research.

Table of Contents

Chapter 1: Introduction	1
Canada's Aging Population.....	1
The Social Concerns of an Aging Population on Healthcare	3
Aging Policies: Active Aging and Social Participation.....	6
WHO's Active Ageing Framework and Age-Friendly Cities.	6
Health benefits of social participation.....	9
Focus on a region in Southern Ontario.....	10
Summary.....	11
Chapter 2: Literature Review.....	13
Definitions of Volunteering.....	13
Understanding Volunteer Work.....	14
Benefits of volunteers for organizations and communities.	16
Volunteer Trends in Canada and Ontario	17
Different patterns between older and younger volunteers.	17
Volunteer trends among older adults.	19
Changing demographics and engagement style.	20
Changing demand for volunteer labour at hospitals.....	21
Volunteer Experiences.....	22
Volunteers as a crucial workforce.....	22
Motivation to start volunteering	23
Motivations of hospital volunteers.	25
Volunteer recruitment.	27
Volunteer retention and turnover.	29
Motivation to continue volunteering.	31
Theoretical Framework.....	31
Social Capital Theory.....	31
Bonding, bridging, and linking social capital.	33
Benefits of social capital on personal health.....	36
Social capital and volunteering.	38
Critiques of social capital theory.....	42
Bridging the Knowledge Gap	44
Purpose of Study and Research Questions	48
Chapter 3: Methodology and Methods	49
Design of the Study	49
Methodological Approach	51
Participant Selection Strategies	53
Participant Profiles	54
Data Collection	58

Phase 1: Document analysis.....	58
Phase 2: Interviews with older volunteers.....	60
List of potential older volunteer participants.....	60
Recruitment strategy.....	61
Data collection strategy.....	61
Phase 3: Key informant interview.....	63
Recruitment strategy.....	63
Data collection strategy.....	64
Internal documents.....	65
Data Analysis.....	66
Category construction.....	66
Criterion to make categories.....	68
Conceptualization.....	68
Overview of data analysis.....	69
Stage 1: Document analysis.....	69
Stage 2: Older volunteer interviews.....	70
Stage 3: Key informant interview.....	70
Trustworthiness	70
Credibility.....	71
Transferability.....	71
Dependability.....	72
Confirmability.....	73
Reflexivity	74
Ethical Issues	74
Research Ethics Board (REB) approval.....	74
Informed consent.....	75
Participant confidentiality.....	77
Chapter 4: Findings.....	79
Case Description.....	79
Overview of volunteers	80
Change Factor	81
Auxiliary Factor	84
Four Overarching Themes	86
Overarching theme 1: Management's influence	86
Recruitment.....	87
Training.....	88
Retention and turnover.....	89
Overarching theme 2: Reasons to volunteer	91
To start volunteering	91
To continue volunteering.....	93

Overarching theme 3: Connections with others.	94
Relationships developed among older volunteers.....	95
Facilitating factors	96
Hindering factors	98
Bonding benefits.....	99
Relationships developed with staff.	100
Facilitating factors	102
Hindering factors	102
Linking benefits for hospitals	104
Relationships developed with patients, families, and the community	104
Facilitating factors	107
Hindering factors	108
Benefits for older volunteers	109
Benefits for patients and families	110
Benefits for the community	111
Conclusion of the connections with others theme	112
Overarching theme 4: Negative experiences of volunteering	113
Summary of Findings	115
Chapter 5: Discussion	120
Overview of Volunteers.....	120
Reasons to Volunteer.....	121
Motivation to start volunteering	121
Motivation to continue volunteering	123
Management’s Influence	124
Recruitment.	124
Volunteer retention and turnover	125
Negative Experiences of Volunteering.....	127
Connections with Others	128
Bonding social capital and benefits.....	128
Bridging social capital and benefits	130
Linking social capital and benefits	132
Factors influencing social capital development	132
Facilitating factors	133
Hindering factors	134
Chapter 6: Conclusion	136
Summary of the Study	136
Limitations and Strengths	139
Implications for Future Research	141
Implications for Future Practices.....	143
Conclusive Remarks	145

References.....	147
Appendix A: Email Script to Older Volunteers.....	164
Appendix B: Telephone Script Initial Contact with Potential Older Volunteer Participants	165
Appendix C: Letter of Invitation to Older Volunteers.....	167
Appendix D: Telephone Script Follow-up to Initial Email/Phone Call to Older Adults	169
Appendix E: Informed Consent Form for Older Volunteers	170
Appendix F: Older Volunteer Interview Guide	174
Appendix G: Email Script to Key Informants	177
Appendix H: Letter of Invitation for Key Informants	178
Appendix I: Informed Consent Form for Key Informants.....	180
Appendix J: Key Informant Interview Guide	184

List of Tables

Table 1. <i>Participant Profiles</i>	56
Table 2. <i>Community Hospital Network Sites</i>	80
Table 3. <i>Changes in the Network's Hospital Sites</i>	82
Table 4. <i>Auxiliaries in the Community Hospital Network</i>	85
Table 5. <i>Non-Auxiliary Volunteer Roles</i>	159
Table 6. <i>Auxiliary Volunteer Roles Except for Fundraising</i>	161
Table 7. <i>Auxiliary Fundraisers</i>	163

List of Figures

<i>Figure 1.</i> Literature Map.....	47
<i>Figure 2.</i> Data Collection Phases.....	58
<i>Figure 3.</i> Data Analysis Strategies for Interview and Document Data	69
<i>Figure 4.</i> The Three States of the Hospitals in the Community Hospital Network.....	83
<i>Figure 5.</i> The Experiences of Older Adults as Volunteers in the Community Hospital Network.....	116

Chapter 1: Introduction

The purpose of this qualitative study is to explore volunteerism among older adults in a community hospital network in Southern Ontario. There will be two objectives for this study. The first objective will be to explore the experiences of older adults' volunteering in hospitals in this network. In this study, I will examine volunteerism as a type of social activity which promotes engagement and social participation among older adults. The second objective is to examine if or how volunteering helps develop social capital for older adults, focusing on the types of social capital and the factors influencing their development. The findings are discussed within the broader policy context of promoting active aging and age-friendly communities (World Health Organization [WHO], 2002; WHO, 2007). In this chapter I will first present an overview of the current issues in regards to population aging and volunteering, then highlight the need to do this research.

Canada's Aging Population

Canada's population is expected to age steadily over the next few decades (Canadian Institute for Health Information [CIHI], 2011). This, in combination with an increase in life expectancy and the aging baby boomer population, has been projected to result in an increase in the population of "older adults" or "senior citizens" (i.e. both terms are used for those who are 65 years and older in this thesis; CIHI, 2011). Individuals over the age of 65 are typically divided into different age cohorts (i.e. young-old, old-old, and centenarians; Aldwin & Gilmer, 2004). However, much of the literature focuses on individuals aged 65 and over as a singular group (Turcotte & Schellenberg, 2006). Turcotte and Schellenberg (2006) state that utilizing the age of 65 as the boundary

is the most plausible, as many organizations and the general public in Canada still recognize this age as when individuals become older adults. This is also due in part to services in Canada, such as the Old Age Security (OAS) pension, which are only given to individuals when they reach the age of 65 years, and Canadian government agencies such as the Public Health Agency of Canada (PHAC), who also recognize 65 as the marker where individuals are considered older adults or senior citizens (Butler-Jones, 2010; Service Canada, 2014).

Within the province of Ontario alone, there were approximately 1,878,325 individuals aged 65 and over, making up 14.6% of Ontario's population in 2011 (Sinha, 2013). In 2013 the number of older adults in Canada was approximately 5.4 million (15.3% of the population), however by 2036 projections show that this number is expected to rise to between 9.9 and 10.9 million, which is a 23% to 25% proportion of the population (Statistics Canada, 2010). Moreover, in 2015 the number of individuals aged 65 and older was higher than the number of children 0 to 14 years of age in Canada (Statistics Canada, 2015).

Though this research referred to older adults aged 65 and over as one singular group, it is important to mention the "old-old" (i.e. those who are 85 years and older), as an increase in this population may be indicative of individuals living for longer and aging healthier. The cohort of adults aged 85 and older is growing the most rapidly compared to other cohorts within the 65 and over age range (CIHI, 2011). They represented 13% of all adults in 2010, and are projected to represent 24% of this population in 2052 (CIHI, 2011). The number of centenarians (i.e. those who are 100 years and older) is also expected to triple or quadruple in number by 2036 (Statistics Canada, 2010). As a result

of these predictions, these demographic changes and their impact have become serious social concerns in Canada.

The Social Concerns of an Aging Population on Healthcare

There is a growing concern that population aging in Canada will put increasing pressure on the Canadian Healthcare system (Canadian Health Services Research Foundation [CHSRF], n.d.; World Health Organization [WHO], 2002). Healthcare is seen as a particularly important issue for Canadians. The 2010 National Report Card on Health Care conducted by the Canadian Medical Association [CMA] which surveyed 3483 Canadians, found three in five Canadians (59%) felt that individuals aged 60 years and older accounted for most of the costs associated with Canada's healthcare, and more than half (56%) noted this same group of individuals would account for these costs over the next 20 years. This public opinion mirrors findings from CIHI (2013), which found that in 2011, the provincial/territorial government health expenditure was greater for seniors than for other age groups across Canada. In addition, in 2011 older adults aged 65 years and over accounted for 45% of provincial/territorial healthcare dollars, though they only composed 14% of the population (CIHI, 2013). The report outlined the most health expenditure per person was for individuals aged 80 years and older (CIHI, 2013). These facts may support the appearance of the “apocalyptic demography” scenario (Robertson, 1997).

Ann Robertson's (1997) paper describes apocalyptic demography as a belief by the general public that there is an unparalleled increase in the aging population, which will result in a higher demand on resources such as healthcare along with increased costs due to older adults living longer but sicker (Verbrugge, 1984 as cited in Robertson, 1997).

This will lead to a depletion of resources for the rest of society, and place an increased burden on the working class to support these older individuals (Robertson, 1997). As a result of this belief that the aging population will deplete societal resources, older adults have been blamed for issues such as rising healthcare costs (Minkler, 1991, as cited in Robertson, 1997).

The perception of the aging population being the main cause of the increasing healthcare cost however, is more of a myth than fact (Canadian Foundation for Healthcare Improvement [CFHI], 2011). The CFHI (2011) found that other factors such as innovations in technology and inflation had a much larger effect on rising healthcare expenditure than did the increase in older adults (CFHI, 2011). In addition, even though older adults used 45% of healthcare dollars in 2011, it only increased by 1% from 2000 (CIHI, 2013). During this same period, there was a 2% increase in the percentage of older adults in the population (CIHI, 2013). Similarly, although older adults aged 80 and over may have the most health costs per person, this is not because of the increase in the aging population per se, but due to factors such as multiple chronic conditions as well as reaching the final years of life, which in turn lead to more expensive medical attention such as longer hospital stays and surgeries (CFHI, 2011; CIHI, 2013). It seems then that the myths surrounding the aging population and the burden they may place on the healthcare system, the “grey tsunami” as described by some, are indeed more of a reflection on the public's perception of old age and possible ageist attitudes, rather than on clear evidence (CHSRF, 2011).

Ageism is still prevalent in Canada. For example, according to a survey conducted in 2012, which asked 1501 Canadians from age 18 onwards on their attitudes towards

aging and ageism, approximately 51% of Canadians found that ageism was “the most tolerated form of social prejudice when compared to gender- or race-based discrimination” (Revera Inc., n.d., p. 5). As evidence of the discrimination faced by older adults, approximately 63% of adults over the age of 65 noted that they were treated differently or unfairly as a result of their age (Revera Inc., n.d.). Ageism appears in several forms. Older adults have noted that the ageism they had experienced include being treated as invisible (41%), assumed to be unable to contribute anything (38%), and seen as incompetent (27%; Revera Inc., n.d.). These statistics indicate that ageism is still a serious concern to tackle within Canadian society.

The contribution of both the government and organizations is needed to combat society-wide negative attitudes on older adults in order to reduce the discrimination against them (CHSRF, 2011; Revera Inc., n.d.). It is possible to mitigate the negative images that society has of old age by recognizing and making visible the contributions of older adults, such as those brought through community volunteering (WHO, 2002). Many older adults are still healthy as they age and should be recognized for their resources that can benefit society (CHSRF, 2011). In fact, the *Living Longer, Living Well* report, a collection of recommendations aimed at developing a strategy to care for aging adults in Ontario, found that compared to previous generations, older Ontarians are living for longer and are reported to be healthier, with less disabilities or chronic illness (Sinha, 2013).

Bringing the literature together, one can see the complexity behind the dominant public discourse on the burden that the aging population will place on the healthcare system. It is not entirely based on facts, rather it is the perception of old age shared by

many Canadians that is fueling this discourse (CFHI, 2011; CMA, 2010). Given global aging, I am concerned about such social attitudes that undermine various contributions that older adults are making to their families, communities, and societies in general. Therefore, this study aimed to explore if and how older adults who are blamed for depriving the healthcare system, could also contribute to it through their volunteer activities. Through this research, this large cohort of older adults can also be viewed as an asset to our healthcare system rather than just be seen as a burden, and in the process change society's perspectives on older adults. In the following section, I will briefly introduce the current political discourse on this issue.

Aging Policies: Active Aging and Social Participation

There has been a turn in gerontology in the last few decades from a focus on the negative to positive aspects of aging (Johnson & Mutchler, 2014; Martinson & Halpern, 2011). The current trend of aging policies is on the encouragement of healthy aging and older adults' continuous active participation in society (Martinson & Halpern, 2011). Activities which facilitate social engagement such as volunteering are also promoted by organizations and governments under the premise of promoting healthy aging (Martinson & Halpern, 2011). As such, the current political discourse of healthy or active aging aims at increasing the well-being and quality of life of older adults through promoting active and engaging lifestyles (Martinson & Halpern, 2011).

WHO's Active Ageing Framework and Age-Friendly Cities. The WHO's (2002) Active Ageing Framework extends from this focus on the positive aspects of aging. Active aging is outlined to be “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002,

p. 12). The Active Ageing Framework uses an inclusive “rights-based” approach to aging which postulates the ability of older adults to actively engage in opportunities and to be equally treated by others, in order to maintain the quality of later life (WHO, 2002).

There are several benefits to implementing an Active Ageing Framework within a community (WHO, 2002). For instance, economic benefits may arise due to the number of people working longer since they are less hindered by health-related disabilities (WHO, 2002). There may also be a slower increase in health expenditure as a result of a decrease in individuals who have poor health and disabilities as they age, resulting in less medical expenses (WHO, 2002).

The Active Ageing Framework takes into account the broad determinants that affect the outcome of healthy and active aging by individuals (WHO, 2002). One key determinant of the Active Ageing Framework is social support, which is under “social determinants” (WHO, 2002). Without it, there is the possibility for individuals to experience a decrease in both physical and psychological health and well-being (WHO, 2002). As older adults may lose social connections as they age, governments and organizations should provide them with various opportunities to create new social support networks through venues such as volunteerism, and other community-based programs in order to encourage frequent social interaction (WHO, 2002). These will in turn sustain and develop supportive environments in communities, as activities such as volunteer work provide the community with both social and economic contributions (WHO, 2002). In short, to realize the active aging of individuals, a supportive community environment is necessary.

The Age-Friendly Cities project is a means by which active aging can be

operationalized within communities (WHO, 2007; WHO, 2009). The WHO (2009) states that “an age-friendly city is an inclusive and accessible urban environment that promotes active ageing” (p. 1). Specifically, it enables active aging through improving the social, economic and environmental factors which influence individuals in order to support aging well in the community (WHO, 2007; WHO, 2009). The eight features of an ideal age-friendly city include: housing, transportation, social participation, outdoor spaces and buildings, community support and health services, respect and social inclusion, communication and information, and civic participation and employment (WHO, 2007).

Social participation and civic participation are two main ingredients of an age-friendly community (WHO, 2007). Older adults who were from Canadian rural communities noted that social participation and the development of social networks were determined by how they got involved in their community (Public Health Agency of Canada [PHAC], n.d.). Some examples of these include organized activities through churches, sports-related events, and community potlucks (PHAC, n.d.). In regards to community volunteering, participants noted that it was an important activity for older adults as it encouraged participation, kept individuals active, allowed them to contribute back to the community, and improved the community's well-being (PHAC, n.d.). They suggested creating recruitment and motivation strategies specifically aimed at getting a wide array of older adults to participate in these activities (PHAC, n.d.). In addition, the City of Brantford (2008) consulted service providers, older adults, and community leaders on what the needs are for their older adults. Their findings stated that issues such as awareness, variety of activities, and social isolation are all concerns when looking at how to include more social opportunities for older individuals (City of Brantford, 2008).

Moreover, results comparable to those in the studies by PHAC (n.d.) and the City of Brantford (2008), were found in the WHO's (2007) international study. They found that activities such as volunteering needed to be increased and catered to a wide array of older adults (WHO, 2007). Furthermore, participants from this study stated social isolation was also a cause for concern, but it could be somewhat mitigated by concentrating recruitment and motivation strategies towards older adults (WHO, 2007).

Health benefits of social participation. The political discourse of active aging and developing age-friendly communities is based on the assumption that social participation is a key component to achieve healthy and active aging (WHO, 2002; WHO, 2007; WHO, 2009). Gilmour (2012), using data collected from the 2008/2009 Canadian Community Health Survey – Healthy Aging, found that as the number of activities increased, there was a higher likelihood of reporting positive self-perceived health and a decrease in reporting life dissatisfaction or loneliness. This suggests that social participation, and volunteering as an indicator of social participation, does benefit the health and well-being of older adults (Employment and Social Development Canada, 2014; Gilmour, 2012). Gilmour's (2012) study added support to the accumulating evidence that ongoing social participation is a predictor of reporting healthy aging (Bennett, 2005; Ichida et al., 2013; Mendes de Leon, 2005). It is particularly important to ensure that older adults are able to engage in social participation as they age, especially in lieu of the fact that social isolation has been shown by the literature to be a predictor of poor health (Cornwell & Waite, 2009; House, Landis, & Umberson, 1988 as cited in Cornwell & Waite, 2009; Coyle & Dugan, 2012; Seeman, Kaplan, Knudsen, Cohen, & Guralnik, 1987).

Focus on a region in Southern Ontario. The region in Southern Ontario where this case study was conducted, had joined the international age-friendly initiative in order to “create safe and secure environments that foster community participation, personal health and well-being” ([Region Name], 2014c). They asked older adults in fall of 2012 as part of their Aging Well in [Region Name] study, on how the region would be able to better support those who want to age well in the community ([Region Name], 2014b). Amongst other suggestions, individuals noted social isolation, a need for additional programs to improve social interaction, and more ways to volunteer in order to become socially connected, as areas that need to be targeted in order to help the increasing older population age well ([Region Name], 2014b).

The proportion of this region’s population aged 65 and older is increasing and continues to be higher than both the provincial and Canadian proportions ([Region Name], 2014a). In 2013, the proportion of older adults in the region was 16.2%, while in Ontario it was 12.7%, and 12.9% for all of Canada (Statistics Canada, 2013b). In addition, this region predicts that approximately 60% of the population growth between 2011 and 2031 will be attributed to those aged 65 and older, and will be a result of the influx of both individuals reaching the age of 65, and individuals over the age of 65 moving to the region to retire ([Region Name], 2014a; The Globe and Mail, Feb. 25, 2014). As such, this region needs to be able to create an age-friendly environment to encourage them to age actively and well in the community.

It is challenging to promote active aging and develop age-friendly communities. Among other suggestions, creating social connections and networks is one aspect of enabling individuals to actively age, and was seen to be one of the issues needing

attention in the Aging Well in [Region Name] study ([Region Name], 2014b). By enabling individuals to develop social connections through volunteering activities, and allowing older adults to contribute back to their community by volunteering in organizations such as hospitals, it can be possible to help older adults age well in this region, thus supporting the development of an age-friendly community.

Summary

It is important to shed light on volunteering as a community engagement and social participation opportunity for older adults. There has been an increase in the number of older adults in both this Southern Ontario region and Canada, and they are living for longer and healthier ([Region Name], 2014a; Sinha, 2013; Statistics Canada, 2013b). At the same time, there is concern from the public on the apocalyptic demography scenario, where an increase in older adults will deplete social resources, place pressure on the healthcare system, and burden younger generations (CHSRF, 2011; CMA, 2010; Minkler, 1991, as cited in Robertson, 1997; Robertson, 1997; WHO, 2002). While the concern that the aging population will overwhelm the healthcare system has been found to be based more on myth or ageism, it is also an inevitable reality that there is a growing social concern on the healthcare system's sustainability as a result of the predicted demographic change (CFHI, 2011; CIHI, 2011; CIHI, 2013). In addition, there is a risk of social isolation which ends in poor health for the older adult, thus social participation, including community volunteering, can be an important method by which to reduce isolation (Cornwell & Waite, 2009; Coyle & Dugan, 2012; Employment and Social Development Canada, 2014; Gilmour, 2012; House, Landis, & Umberson, 1988 as cited in Cornwell & Waite, 2009; Seeman et al., 1987). Based on these socio-political contexts, I explored

volunteer experiences of 10 older adults at hospitals in a community hospital network in Southern Ontario as a form of social participation, which may serve as an effective means to enable older adults to actively age in the community. I also examined if and how older adults can be contributors to support the healthcare system.

This thesis is organized into six chapters. In Chapter Two, I conducted a review of the literature on volunteerism, older adults' volunteer experiences, and social capital theory as the analytic framework. Chapter Three provides a detailed description of my research approach and methods. In Chapter Four, I present my major findings from the study. Chapter Five compares my findings back to the previously found literature in this area. Lastly, Chapter Six provides a summary of the research including limitations and strengths, key lessons learned from the case, as well as my conclusive remarks on how this study may add and affect future research and practices, tying back to the active aging and age-friendly community frameworks.

Chapter 2: Literature Review

The following chapter provides a review of the literature on volunteering. It starts with a general definition and understanding of volunteer work, followed by volunteer trends in both Canada and the Province of Ontario. The review then moves onto volunteers' experiences, which includes motivations of older volunteers, motivations of hospital volunteers, benefits of having volunteers for the organization and communities, volunteer recruitment, and volunteer retention and turnover. Afterwards I will review social capital theory, which is the theoretical lens used to frame this research. The chapter ends with a Bridging the Knowledge Gap section as well as a statement of the main purpose of the study and research questions.

Definitions of Volunteering

There are several definitions of volunteering. Wilson (2000) defines the act of volunteering as “any activity in which time is given freely to benefit another person, ground or cause” (p. 215). Volunteer Canada (2012) further states that volunteering is “the most fundamental act of citizenship and philanthropy in our society. It is the offering of time, energy and skills of one’s own free will” (p. 22). As such, volunteering is proactive rather than reactive, and an individual who engages in volunteering does so as a result of a preconceived decision or plan (Wilson, 2000). For the purposes of this research, I employed the definition provided by Volunteer Canada (2012), as it specifies on how the individual's time as well as energy and skills are given when engaging in volunteer activities.

Volunteering can be dichotomized into one of two types, namely, formal or informal volunteering (Wilson & Musick, 1997). Formal volunteering is defined as when

an individual volunteers on behalf of an organization without pay (Wilson & Musick, 1997). Informal volunteering occurs when one provides some sort of assistance on their own, such as running errands, rather than on the behalf of an organization (National Seniors Council, 2010; Wilson & Musick, 1997). Based on this classification, older adults volunteering in hospitals will be categorized as “formal volunteering”.

Understanding Volunteer Work

Volunteering can be viewed from different disciplines and perspectives. This study used Wilson and Musick’s (1997) sociological perspective as the basis for understanding volunteering. Wilson and Musick (1997) developed a comprehensive theory of volunteer based on four premises. The first is that volunteering is a productive activity, meaning that it has a market value and is a form of labour (Wilson & Musick, 1997). As a result, volunteering differs from altruism, though volunteering can have altruistic values attached to it (Wilson & Musick, 1997). The second premise is that volunteering involves some form of collective action for social causes (Wilson & Musick, 1997). Third, the relationship between the volunteer and the recipient is ethical and should be considered to be a moral cause where individuals are giving their time to others (Wilson & Musick, 1997). The final premise is that different types of volunteering are interrelated, thus the level of formal volunteering should somewhat predict the level of informal volunteering and vice versa (Wilson & Musick, 1997).

Wilson and Musick (1997) also proposed three capitals, *human capital*, *social capital*, and *cultural capital*, as endogenous factors for volunteering. Human capital refers to resources that are attached to individuals for productive activities to occur (Wilson & Musick, 1997). It includes functioning health, education, and income (Wilson

& Musick, 1997). In regards to formal volunteering, human capital relates to the availability and the qualifications of individuals to volunteer, as well as how appealing an individual is to a host organization (Wilson & Musick, 1997). Social capital on the other hand, refers to the networks, trust, reciprocity and connections that, in this case should increase the likelihood of individuals' involvement in volunteering (Wilson & Musick, 1997). It results in the development of social support networks and informal social interactions (Wilson & Musick, 1997). The third capital is cultural capital, and was used to describe how individuals value the act of helping others, and whether they see volunteering as a symbolic good (Wilson & Musick, 1997). Religiosity is one of the examples often used to measure this capital (Wilson & Musick, 1997).

Wilson and Musick (1997) put forward this volunteer theory based on their study which used data from a two-stage panel survey named Americans' Changing Lives. Respondents were 25 years or older and resided in the USA (Wilson & Musick, 1997). The first wave, in 1986 consisted of 3617 respondents, while the second in 1989 had 2854 (Wilson & Musick, 1997). The authors found formal volunteering was positively related to human capital, religiosity, informal social interaction, and number of children in the household (Wilson & Musick, 1997). Informal volunteering on the other hand, was positively related to age, gender, and health (Wilson & Musick, 1997). They also found that only formal volunteering predicts informal volunteering and not vice versa (Wilson & Musick, 1997). In addition, socio-demographic factors such as age, race and gender had a mainly indirect effect on volunteer work, and more so determined the amount of capital gained through volunteering (Wilson & Musick, 1997). This meant that social capital variables were positively related to formal volunteering rather than informal

volunteering (Wilson & Musick, 1997). The authors interpreted that these results stemmed from the different nature of formal (public) and informal (private) volunteering (Wilson & Musick, 1997).

Benefits of volunteers for organizations and communities. There are benefits for the organization and the surrounding community as a result of individuals' volunteering activity (Handy & Srinivasan, 2004). Handy and Srinivasan (2004) conducted a study on the benefits of having volunteers in hospitals. They conducted a cost-benefit analysis of using volunteers and volunteer programs in 31 hospitals within the Greater Toronto Area (Handy & Srinivasan, 2004). Through conducting surveys and holding interviews with the volunteer managers, clinical staff members who supervise volunteers, and the volunteers themselves, they calculated that for every dollar spent on volunteers the hospitals received \$6.84, which is a return investment of 648% (Handy & Srinivasan, 2004). This value includes the cost of recruitment, screening, training and supervision of volunteers, as well as the cost of staff for the volunteer program (Handy & Srinivasan, 2004). Handy and Srinivasan (2004) also found that volunteer managers and staff felt that volunteers increased the quality of patient care within hospital settings. Patient care was defined in this case to be any type of personal interaction between the volunteer, and the patient and their families (Handy & Srinivasan, 2004). In addition, volunteers helped decrease staff workloads and were seen as essential for successful public relations as they are a key link to the surrounding communities (Handy & Srinivasan, 2004; Handy & Srinivasan, 2005). From these findings, it seems that the benefits received by hospitals in terms of cost savings and increased quality of care through their volunteer program are worth the costs they incur as a result of engaging

volunteers.

Rogers, Rogers, and Boyd (2013) conducted a study to determine the challenges and opportunities that affect volunteer management in hospitals using the perspectives of the volunteer administrators. Surveys were mailed in 2011 to hospitals in five states across the northeast and southern United States, of which the 105 responses given by volunteer administrators were analyzed using content analysis (Rogers et al., 2013). Rogers et al. (2013) found that in regards to opportunities, the largest opportunity created through recruiting volunteers in hospitals is the positive impact that it will have on the surrounding community as well as on the patients. Participants specifically felt that volunteers could build strong bonds and boost patient satisfaction scores, which coincide with the findings by Handy and Srinivasan (2004) and Handy and Srinivasan (2005), which also found that volunteers have a great impact on both the patients and the surrounding community.

Volunteer Trends in Canada and Ontario

Different patterns between older and younger volunteers. Throughout the years, Canadians have been consistently participating in volunteer activities (Cook & Sladowski, 2013; Vézina & Crompton, 2012). Approximately 13.3 million people (47%) of all Canadians aged 15 years and older participated in some form of volunteering in 2010 (Vézina & Crompton, 2012). Between 2007 and 2010, the number of volunteers aged 15 and over significantly increased by 6.4%, however the number of hours given to volunteer work remained consistent at 2.07 billion hours (Vézina & Crompton, 2012). The type of organization for which older Canadians volunteered was different when compared to all Canadians (Cook & Sladowski, 2013; Vézina & Crompton, 2012). In

2010, approximately 66% of the total volunteer hours across Canada went to non-profit organizations focusing in five specific areas: sports and recreation, social services, education and research, religion, and health (Vézina & Crompton, 2012). In Ontario, 19% of all volunteers engaged in health-related organizations while 16% engaged in social services (Volunteer Canada, n.d.). In contrast, when looking at older Canadians aged 65 or older, 13% volunteered for religious organizations, followed by sports and recreation at 9%, and social services at 9% (Cook & Sladowski, 2013). It is notable that the volunteer rate for hospitals for older adults was only 3% (Cook & Sladowski, 2013).

As one ages, the likelihood of volunteering decreases, while the number of hours put in by these volunteers increases (Vézina & Crompton, 2012). In 2007, 58% of those Canadians aged 15 to 24 years old volunteered with an annual average of 138 hours, while only 36% of those aged 65 years and older did so with an annual average of 218 hours (Hall, Lasby, Ayer, & Gibbons, 2007). These percentages were stable between 2007 and 2010 (Vézina & Crompton, 2012). The average number of volunteer hours however, slightly decreased to 130 for those aged 15 to 24, while the hours contributed by older adults aged 65 and older increased to 223 hours in 2010 (Vézina & Crompton, 2012). According to Vézina and Crompton (2012), this inverse relation between the number of volunteer hours and the volunteer rates are partially due to mandatory volunteer hour requirements for the youth, and a result of health issues for the old. In fact, 58% of those aged 65 to 74, and 78% of those aged 75 and older reported health as one of the main reasons why they did not volunteer (Vézina & Crompton, 2012). However, the older adults who were able to volunteer contributed to significantly longer hours (Vézina & Crompton, 2012). As the number of hours contributed are higher amongst the older

adult group, they are also more likely to be in the category called “top volunteers” (National Seniors Council, 2010). These top volunteers are the 25% of the volunteer population who contribute over 171 hours per year and in 2007, accounted for over 78% of all the volunteer hours in Canada (National Seniors Council, 2010). In regards to older adults, 13% of all individuals aged 65 and older were considered to be top volunteers (Vézina & Crompton, 2012).

Volunteer trends among older adults. Cook and Sladowski (2013) found through their calculations with the 2010 Canadian Survey of Giving, Volunteering and Participating [CSGVP] data that separating the 65 year and older group by age and sex also affected volunteering rates and hours. For example, the cohort aged 65 to 74 years had a volunteer rate of 40% with 235 average hours contributed per year, while those aged 75 years and older had a volunteer rate of only 31% and contributed approximately 198 hours per year (Cook & Sladowski, 2013). In addition the volunteer rate and average hours per year for males aged 65 and older was 38.8% and 223 hours respectively (Cook & Sladowski, 2013). This is in comparison to females who had a 34.6% volunteer rate (Cook & Sladowski, 2013). The average number of hours stayed the same at 223 (Cook & Sladowski, 2013).

There were also individual characteristics which correlated with differences in volunteering between individuals in the 65 year and older cohort (Cook & Sladowski, 2013). Cook and Sladowski (2013) found that higher education and higher household income were positively correlated with an increase in volunteer rates. They also found that there was a higher rate of volunteering for those who were employed in comparison to those not in the labour force (Cook & Sladowski, 2013). In addition, the statistic for

the volunteer rate of unemployed individuals aged 65 and older was unavailable, and thus it is uncertain the effect that being unemployed has on the volunteer rate (Cook & Sladowski, 2013). In regards to the average number of volunteer hours, when compared to the 45 to 54 year and 55 to 64 year cohort, individuals 65 years of age and older had the highest value (Cook & Sladowski, 2013). Moreover, individuals 65 or older with no children in their household had the highest average number of volunteer hours (Cook & Sladowski, 2013).

Changing demographics and engagement style. Organizations have seen a change in the demographics of their volunteer base (Volunteer Canada, n.d.). In Ontario, Volunteer Canada (n.d.) conducted an online survey with 157 organizations in 2010 in order to determine the trends in volunteers from the viewpoint of managers, executive directors and other administrative positions. The majority of the organizations (57%) were from the areas of health, social services, education, and research (Volunteer Canada, n.d.). Nearly half (46%) of the organizations surveyed saw a change in volunteer demographics, with half of this group (51%) stating that their volunteer base has become younger, while 17% noted the aging of their volunteers, and that more of these older volunteers were leaving their positions due to their advanced age (Volunteer Canada, n.d.).

The same survey also found changing trends in volunteers' preference of placements and their skills (Volunteer Canada, n.d.). Individuals came to prefer short-term volunteering, resulting in some organizations having to change their minimum requirement over the past five years to match this (Volunteer Canada, n.d.). In addition, approximately half of the organizations said they did not have a strategy in place to

recruit and handle the increasing number of skill-based volunteers (Volunteer Canada, n.d.). Approximately one-third of organizations also reported overall difficulties in volunteer recruitment (Volunteer Canada, n.d.).

Changing demand for volunteer labour at hospitals. Handy and Srinivasan (2005) conducted a study to determine the factors which may affect an organization's demand for volunteers in hospitals. Data was collected through interviews with the CEOs of 28 hospitals in the greater metropolitan area of Toronto, as well as using previous data already available on the hospitals' volunteer programs (Handy & Srinivasan, 2005). The majority of CEOs in this study received information on their volunteer programs in the form of qualitative and quantitative reports, and informal feedback from individuals (Handy & Srinivasan, 2005).

The results indicated that even though there was a continuous supply of volunteers available, the hospitals indicated who they chose based on a number of factors, one of the main ones being the cost of using volunteers in these organizations (Handy & Srinivasan, 2005). Handy and Srinivasan (2005) found that hospitals would prefer to have long-term volunteers, given the cost associated with a higher turnover rate of short-term volunteers. Handy and Srinivasan (2005) also found that hospitals see volunteers as a cost-inducing factor to the organization even though the volunteers do not receive direct wages. According to the CEOs, volunteers incur costs to the organization through the recruitment, training and supervision of volunteers (Handy & Srinivasan, 2005). They also acknowledged that the lack of resources played a major role in the hospital's ability to manage a large population of volunteers (Handy & Srinivasan, 2005). It seems then that an organization's financial resources play a large role in determining the demand for

volunteer labour.

According to Handy and Srinivasan (2005), the general trend for volunteer demand in Toronto hospitals was a downward slope, and it was more difficult to find volunteers who were willing to fill in specialized roles. Handy and Srinivasan (2005) postulated that this decreasing demand was a possible result of the increase in cost per hour of volunteer labor. The results of their study also suggest that the demand for these volunteers fluctuates depending on whether the CEO of the hospital views the volunteers as being integral to the organization's needs (Handy & Srinivasan, 2005). Culp and Nolan (2000) as cited in Handy and Srinivasan (2004) stated that the current number of volunteers, who are short-term and can only contribute a limited number of hours, exceed the demand that hospitals have for this type of volunteer. They noted that hospitals may need to adapt to optimize utility of this new volunteer group who are opting for both less hours and shorter terms (Culp & Nolan, 2000 as cited in Handy & Srinivasan, 2004). The authors concluded that there is not an infinite demand for volunteers, and that non-profit organizations such as hospitals need to focus on existing volunteers in order to maximize their effectiveness in regards to cost, labour and benefits to the hospitals, staff, patients and volunteers themselves (Handy & Srinivasan, 2004; Handy & Srinivasan, 2005). If organizations do decide to focus on engaging volunteers, they may face challenges in regards to recruiting, training, and retaining these volunteers.

Volunteer Experiences

Volunteers as a crucial workforce. Volunteers play a key role in maintaining social services in Canada (National Seniors Council, 2010; Volunteer Canada, n.d.). To this end approximately half the non-profit sector relies heavily on the contributions of

volunteers (National Seniors Council, 2010). In Ontario, the majority of the 4600 registered non-profit organizations including charities, are situated in urban centers (Volunteer Canada, n.d.). In particular, volunteers are an essential workforce in our healthcare sector. Their contributions are valued \$14 billion per year in Canada (Martinson & Halpern, 2011; National Seniors Council, 2010).

Motivation to start volunteering. There is extensive research on the motivations for individuals to volunteer (Blanchard, 2006; Narushima, 2005; Zweigenhaft, Armstrong, Quintis, and Riddick, 1996). This section focuses on the motivations of older adults and hospital volunteers to engage in volunteering.

Generativity, reciprocity, and altruism are the terms that often appear in the literature on healthy aging, older adults, and volunteering (Narushima, 2005; Schoklitsch & Baumann, 2012; Scott, Reifman, Mulsow, & Feng, 2003; Zaninotto, Breeze, McMunn, & Nazroo, 2013). The concept of generativity was first introduced by Erikson (1950) as cited in Schoklitsch and Baumann (2012) as the seventh of the eight stages of psychosocial development. Generativity refers to the process involved in caring and guiding future generations, and is considered important for the successful aging of older adults (Schoklitsch & Baumann, 2012). McAdams, de St. Aubin, and Logan (1993) as cited in Scott et al. (2003) stated that volunteering is one method through which generativity can be expressed. Thus generativity can act as a motivator for older adults to volunteer (Narushima, 2005; Scott et al., 2003).

Reciprocity in regards to volunteerism refers to the belief that by putting in effort through volunteering to help someone else, individuals will also be rewarded themselves (Esmond & Dunlop, 2004; Gouldner, 1960 as cited in McMunn, Nazroo, Wahrendorf,

Breeze, & Zaninotto, 2009). Increased reciprocity from volunteerism or other socially productive activities has been shown to improve social engagement as well as increase well-being (McMunn et al., 2009; Wahrendorf, Knesebeck, & Siegrist, 2006; Zaninotto et al., 2013). Thus reciprocal exchange is integral for older adults and social engagement in activities such as volunteerism, and can act as a motivator to volunteer (McMunn et al., 2009; Zaninotto et al., 2013).

These two key motivational concepts (i.e. generativity and reciprocity) were also found in a study of older community volunteers in Canada (Narushima, 2005). Narushima (2005) conducted a qualitative study to explore the experiences of older adults engaged as formal volunteers, in non-profit organizations within the City of Toronto. She used a case-study approach to analyze data collected from document analysis, and face-to-face interviews with 12 volunteer coordinators and 15 older adult volunteers (Narushima, 2005). The results indicated that the motivations for older adults to volunteer were a mixture of both an altruistic motive, such as for a social cause, as well as self-interest and an egotistic motive such as desires to use and cultivate their lifetime skills (Narushima, 2005). This study also found “generativity” was a motivational factor, as older adults wished to take care of the other generations (Narushima, 2005). As a result of this combination, the participants in the study used phrases such as “wanting to give back to society” rather than saying that their volunteer work was a result of pure altruistic desires (Narushima, 2005). In addition, volunteers had the most positive reactions to roles which provide interactions with other individuals such as a volunteer recruiter, tutor or friendly visitor (Narushima, 2005). Volunteers also enjoyed positions which allowed them to use the skills they had learned over the years and which gave them an

opportunity for “continued learning” (Narushima, 2005). This study, as others, indicates that the volunteer role or position offered can act as both a motivation and reward for older adults to volunteer (Morrow-Howell, Hong, & Tang, 2009; Narushima, 2005).

The findings from Narushima’s work (2005) correspond to the analysis of the 2010 CSGVP data by Cook and Sladowski (2013). The majority, 95%, of older adults stated that they wanted to make a contribution back to the community as their reason for volunteering (Cook & Sladowski, 2013). The opportunity to use their skills and experience was cited as a reason by 82% of individuals (Cook & Sladowski, 2013). In addition, 59% stated that they volunteered because they were personally affected by what the organization supported (Cook & Sladowski, 2013). Many older adults also volunteered in order to develop social networks and meet new individuals; 57% of individuals named this reason (Cook & Sladowski, 2013). As well, approximately 53% of individuals volunteered because their friends volunteered (Cook & Sladowski, 2013). These studies indicate that older adults have motivations to volunteer stemming from different motives (Cook & Sladowski, 2013; Narushima, 2005). Based on this research, I included these concepts of motivation as they are important to how older adults are engaged as volunteers. Though older adults have different motives to engage in volunteerism, it was important to determine whether hospital volunteers, including the older volunteers in the community hospital network, also had similar motives.

Motivations of hospital volunteers. Zweigenhaft et al. (1996) conducted a study on the effectiveness and motivations of hospital volunteers. They provided a survey to be completed by 98 volunteers at a hospital in North Carolina, and asked the director of volunteer services to rate the volunteers (Zweigenhaft et al., 1996). The sample consisted

of individuals aged 14 to 89, with 58% who were over 60 years of age (Zweigenhaft et al., 1996). Results found that the majority volunteered for reasons such as it giving them “a good feeling or sense of satisfaction to help others” (Zweigenhaft et al., 1996, p. 29), “I feel I should give something back to society since I am so fortunate” (Zweigenhaft et al., 1996, p. 30), and being “concerned about those less fortunate than I” (Zweigenhaft et al., 1996, p. 29). The three items mentioned here refer to egoistic, social-obligation, and altruistic motivations of volunteers respectively (Zweigenhaft et al., 1996). It seems that hospital volunteers’ motivations come from a variety of different motivational forces, which was also found in Narushima’s (2005) study on older volunteers.

Blanchard (2006) conducted a qualitative exploratory study to determine the motivations of hospital volunteers, as well as explore whether differences in age or gender affected these motivations. In-depth interviews were conducted with 21 volunteers (8 males and 13 females), aged 20 to over 80, from a northern California medical center (Blanchard, 2006). The results found that there were no prominent differences as a result of age or gender differences, in regards to attitudes or motivations for volunteer work (Blanchard, 2006). Blanchard (2006) also found that all individuals noted altruistic motives for volunteering, such as giving back to the community and helping someone in need. These results correspond with Zweigenhaft et al. (1996) as well as Narushima's work (2005), which also suggested some sort of altruistic motive for volunteering among older adults. Another similarity with Narushima's work (2005) was that participants' commitments to the position were based on whether it involved direct contact with patients and let them engage in meaningful work (Blanchard, 2006). Blanchard’s (2006) study also found that individuals did not volunteer as a result of

religious or social motivations. The implications from her study suggest that individuals who take part in volunteer recruitment should be cognizant of the personal factors and motivators that affect whether a volunteer will take up a certain position, along with the benefits and difficulties faced by volunteers within that position (Blanchard, 2006).

Volunteer recruitment. In order to recruit older volunteers effectively, organizations need to adapt to the needs expressed by this group of individuals (Nagchoudhuri, McBride, Thirupathy, Morrow-Howell, & Tang, 2005). Nagchoudhuri et al. (2005) conducted a study which focused on the second phase of a two-phase project on institutional capacity for older adult volunteers. They assessed the perceptions of older adults on organizations' efforts to recruit and retain volunteers, as well as the volunteer roles themselves, through conducting four focus groups with 43 volunteers over 60 years of age, from 13 organizations in the St. Louis metropolitan area (Nagchoudhuri et al., 2005). Overall, the findings suggest that older adults are recruited into organizations through informal means, such as being a previous client or having close acquaintances already volunteering with the organization, rather than through formal recruitment efforts such as advertisements (Nagchoudhuri et al., 2005). Familiarity with the organization influences the older adults' decision to volunteer there (Nagchoudhuri et al., 2005). Nagchoudhuri et al. (2005) also found that practical and moral incentives for older adults to volunteer, such as personal satisfaction and recognition by the organization, were key factors in determining whether they kept volunteering. The third factor found by Nagchoudhuri et al. (2005) was facilitation or in other words, support and flexibility of volunteer roles and tasks. The older adults stated that the organization's involvement and understanding of the individual volunteer's needs such as responding to their concerns,

including them in important decision-making, and verbally appreciating the work they do, all contribute towards the motivation to remain as a volunteer (Nagchoudhuri et al., 2005). These findings by Nagchoudhuri et al. (2005) suggest that organizations need to be proactive in engaging older adult volunteers, especially employing informal recruitment methods involving family and friends.

The needs of strategic recruitment for older volunteers was also found in another study conducted by the National Seniors Council (2010). They organized eight roundtables, which included community representatives and older adults, and asked about their concerns regarding volunteering of older adults (National Seniors Council, 2010). In regards to volunteer recruitment, participants stated that older adults who are low income, socially isolated, or have health issues are difficult to recruit (National Seniors Council, 2010). They also noted that the current state of the economy may require more individuals to work longer for pay in order to ensure enough savings for retirement (National Seniors Council, 2010).

In regards to recruitment techniques, participants suggested raising awareness of opportunities by approaching these older adults directly through going to locations where they congregate such as community centers (National Seniors Council, 2010). Creating a “culture” of volunteering, in other words to make it a key component of civic engagement for older adults as well as creating a social marketing campaign to promote volunteerism, was suggested in order to improve recruitment rates (National Seniors Council, 2010). Participants stated that recruitment strategies such as using the internet may not be effective for older adults, because many older adults today may not identify themselves as “seniors”, thus ignoring recruiting attempts (National Seniors Council,

2010). The study concluded that it is important to focus on the senior population as a large potential volunteer pool, as they are mainly overlooked in recruitment strategies (National Seniors Council, 2010).

Volunteer retention and turnover. There are a number of factors, once an individual is “hired”, which may cause them to leave their volunteer work (Volunteer Canada, n.d.). In 2010, Volunteer Canada (n.d.) conducted a second-data analysis of a general population telephone survey with 1019 residents of Ontario. The purpose was to understand trends in volunteers today as well as to speculate how to engage with volunteers in the future (Volunteer Canada, n.d.). Of these individuals, 55% were current volunteers, 34% were past volunteers, and 12% had never volunteered before (Volunteer Canada, n.d.). The former volunteers listed the reasons to quit such as a lack of time, health, age, their children growing up, moving to a different area, and lack of opportunity as reasons to why they stopped volunteering (Volunteer Canada, n.d.).

In the same vein, Tang, Morrow-Howell, and Choi (2010) examined the program and individual-level factors which may cause older adults to stop volunteering in the U.S. They used telephone interviews and mail surveys to question 207 older adult volunteers who served in ten programs across ten states (Tang et al., 2010). These adults were aged 56 to 89, with only 13 of the respondents less than 60 years of age (Tang et al., 2010). Of these participants, 48 volunteers had stopped volunteering and 159 were still volunteers (Tang et al., 2010). Tang et al. (2010) used bivariate analysis and logistic regression analysis for quantitative data, and content analysis for qualitative data. The findings showed that the majority of older adults (86%) were likely to volunteer in areas which provide supportive and direct services (Tang et al., 2010). They also calculated nine

factors to be significant in predicting volunteer turnover, two of which, income and mental health status, were directly related to the individual (Tang et al., 2010). The other seven factors were related to the program directly, such as the type of position, the payment of stipends, and duration of volunteering (Tang et al., 2010). Based on their qualitative analysis, Tang et al. (2010) found that having other commitments, decline of health, and issues with the volunteer environment were reasons why the 48 past volunteers stopped volunteering. Tang et al. (2010) concluded that both the type of volunteer activity matters, as well as the organization's involvement and support for the volunteers. In a sense, this study suggested that organizations are highly responsible for ensuring that they do not have a high volunteer turnover rate (Tang et al., 2010).

Compared to the aforementioned study by Tang et al. (2010), Ontarian volunteers seem to list more personal reasons as to why they have stopped volunteering. When asked about negative experiences in volunteering, approximately 39% of respondents from the study by Volunteer Canada (n.d.) noted organizational factors such as dealing with rude individuals, politics, poor organization, type of work involved, and lack of appreciation. It seems that volunteers' negative experiences in the organizations were commonly found in both studies, although the reasons for turnover were somewhat different.

Moreover, aforementioned Cook and Sladowski's (2013) study on older volunteers found that the main factors which hindered older adults from volunteering more were giving enough time already (57%), not having the time to do so (52%), and the inability to keep a long-term commitment (52%). When compared to those in the 45 to 54 and 55 to 64 age groups, individuals aged 65 or older were more likely to state

health or physical barriers as reasons to not volunteer more (36%; Cook & Sladowski, 2013). Cook & Sladowski's (2013) research suggests that organizations may need to focus on targeting individual barriers in order to retain volunteers for longer.

Motivation to continue volunteering. The literature indicates that volunteers stay longer at the same organization if they are motivated (Claxton-Oldfield & Claxton-Oldfield, 2012). Claxton-Oldfield and Claxton-Oldfield (2012) conducted a study on multiple topics related to volunteer retention, satisfaction, and motivation to continue volunteering. They conducted informal group discussions, on hospice palliative care volunteers in New Brunswick (Claxton-Oldfield & Claxton-Oldfield, 2012). There were 41 participants, of which 34 were female, and the average age was 66.9 years (Claxton-Oldfield & Claxton-Oldfield, 2012). Claxton-Oldfield and Claxton-Oldfield (2012) found several reasons to continue volunteering. The main reason given by participants was that it made a difference or helped others (Claxton-Oldfield & Claxton-Oldfield, 2012). Another reason stated by participants was their enjoyment or personal satisfaction from their volunteering (Claxton-Oldfield & Claxton-Oldfield, 2012).

Theoretical Framework

This study analyzed the relationships generated at the hospitals between older adult volunteers, patients, staff, and the surrounding communities, using *social capital theory* as an analytic framework.

Social Capital Theory. The current view of social capital theory was developed mainly through the work of Robert Putnam and James Coleman (Woolcock & Narayan, 2000). Putnam (1995), in his paper "Bowling Alone: America's Declining Social Capital", describes the eroding state of America's civic society over the past few decades

and postulates some factors which may be causing this decrease in social capital. He defines *social capital* as the “features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam, 1995, p. 2).

Therefore, social capital can be affected by minute changes in the structure of the organization (Coleman, 1990). Social capital can appear in numerous forms but always “consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure” (Coleman, 1990, p. 302). According to Coleman (1990), social capital is considered to be a resource for individuals and can influence their perception of the quality of life. It is a resource that cannot be exchanged or owned by one individual (Coleman, 1990). Rather, it is a feature of the community in which the person is a part of (Coleman, 1990). McKenzie, Neiger, and Thackeray (2013) note that social capital theory is an interpersonal level theory, and can be used to help explain the interactions between the organizations providing services through their volunteers, and outcomes of the interactions within a specific community setting. As such, numerous forms of social capital are created or lost as a consequence of external factors rather than as a result of an individual’s willingness to do so (Coleman, 1990).

Social capital can appear in various forms – from highly formal forms such as labour unions to an informal group of friends going out to the movies (Putnam, 2001). In this sense, volunteering in a local hospital can be viewed as a form of social capital where volunteers can form networks. According to Putnam (2001), social capital has been generally decreasing as formal and informal participation have been declining.

There are different factors that can be used as proxies for social capital (Putnam,

2001). For instance, *social trust*, which is defined as whether an individual can trust others, can be used as a proxy for social capital (Putnam, 2001). Putnam's (2001) analysis shows that social trust has been declining in the USA. He also suggests that another, less direct measure for social capital is *altruism* (Putnam, 2001). He states that there is strong affinity between altruism and social connectedness, and that altruism is strongly predicted by social connectedness (Putnam, 2001). For example, individuals who are more socially connected volunteer their time and give blood (Putnam, 2001). Putnam (2001) suggests that there is a close relationship between volunteering and social capital, which is also emphasized in aforementioned Wilson and Musick's (1997) general volunteer theory. Putnam's (2001) social capital theory also indicates how social capital acts as a predictor of overall community and individual well-being (Putnam, 2001).

Bonding, bridging, and linking social capital. The more recent research shows that social capital can be divided into different types (McKenzie et al., 2013). McKenzie et al. (2013) state that there are three different types of social network including *bonding*, *bridging*, and *linking*. Bonding refers to bringing individuals who are similar to one another or belong to the same group, closer together (Gittell & Vidal, 1998 as cited in McKenzie et al. 2013). Bridging refers to obtaining resources from individuals who are outside of that person's group (Gittell & Vidal, 1998 as cited in McKenzie et al., 2013). Linking refers to the relationship where one group has a higher position of power than the other, but both groups are working on the same project (McKenzie et al., 2013; Szreter & Woolcock, 2004). Bonding and bridging social capital are seen to be horizontal relationships as they focus on the relationships between individuals who "are more or less equal in terms of their status and power" (Szreter & Woolcock, 2004, p. 6). On the other

hand, linking social capital consists of vertical relationships because they involve individuals who have different levels of status, power and authority (Elgar, Davis, Wohl, Trites, Zelenski, & Martin, 2011; Szreter & Woolcock, 2004). Szreter and Woolcock (2004) further state that linking social capital are built on trust and respect within relationships between individuals of different status and power. These concepts were useful in examining the type of relationships generated by older adult volunteers in the community hospital network in Southern Ontario.

There seems to be a lack of literature on the three different types of social capital in relation to healthcare access (Derose & Varda, 2009; Nyqvist, Forsman, Giuntoli, & Cattani, 2013). Derose and Varda (2009) conducted a systematic review of social capital and how it affected healthcare access. They reviewed 2,396 abstracts from which 21 met the criteria for the study (Derose & Varda, 2009). Only two of these 21 articles used qualitative research methodology (Derose & Varda, 2009). The samples from these studies were varied and did not solely focus on older adults (Derose & Varda, 2009). Derose and Varda (2009) found that none of the 21 articles had distinguished between bonding, bridging, and linking social capital. They also found that linking social capital was “the least developed in the literature” (Derose & Varda, 2009, p. 283), when compared to bonding and bridging social capital. They found from their study that bonding relationships of “good” quality are related to increased healthcare access, however when bonding relationships do not facilitate access, bridging and linking relationships become important for improved healthcare access (Derose & Varda, 2009). In conclusion, they suggest using the three types of social capital in future studies, as well as using more qualitative research to help create theories related to social capital and

healthcare access (Derose & Varda, 2009). Thus my study adds to this need for qualitative literature which looks at the three types of social capital.

Another recent systematic review done by Nyqvist et al. (2013) agree with Derose and Varda (2009), suggesting that since bonding, bridging and linking social capital are relatively new concepts in the health arena, they need to be further studied. Nyqvist et al.'s (2013) systematic review focused on the relationship between social capital and mental well-being in adults who were 50 years of age or older (Nyqvist et al., 2013). They had 11 studies that were published between 2002 and 2011, of which only one focused on these three types of social capital specifically (Nyqvist et al., 2013). One of their main findings was that social capital indeed was usually a positive influence on the mental well-being of older adults (Nyqvist et al., 2013). Nyqvist et al. (2013) mentioned that in regards to future research, it was important to look at the effects that the physical and social environment had on social capital development. My research has tried to add to this gap in the literature by examining the contextual factors that may positively or negatively influence social capital development. It is noteworthy that Nyqvist et al.'s (2013) systematic review did not have any qualitative studies in their review. This suggests the crucial needs of more qualitative research to understand the influence of the three types of social capital on older adults' mental well-being, as well as the influence of environmental factors on social capital development.

The Policy Research Initiative (PRI) conducted by Health Canada (2006) also found that it was important to study social capital within its broader context. They created the PRI framework to help analyze social capital using the network approach (Health Canada, 2006). The PRI framework explicitly states the importance of broad contextual

factors that may affect social capital development (Health Canada, 2006). They acknowledge that social capital cannot be viewed outside of its specific context, as the context may function as resources or vice versa (Health Canada, 2006).

Benefits of social capital on personal health. These is an extensive body of literature on the benefits of social capital on health (Forsman, Herberts, Nyqvist, Wahlbeck, & Schierenbeck, 2013; Health Canada, 2006; Kim, Subramanian, & Kawachi, 2006; Nyqvist et al., 2013; Subramanian, Kim, & Kawachi, 2002; Szreter & Woolcock, 2004; Zunzunegui, Koné, Johri, Béland, Wolfson, & Bergman, 2004). These benefits can come in various forms of improved health such as mental well-being, decreased social isolation, and improved self-rated health (Forsman et al., 2013; Kim et al., 2006; Subramanian et al., 2002; Zunzunegui et al., 2004). One qualitative research study conducted by Forsman et al. (2013) looked at the role that social capital played in the mental well-being for older Finnish adults. They used data from the previously conducted 2008 Western Finland Mental Health Survey, as well as from two focus groups with older adults who were recruited from a nursing home and a retirement association (Forsman et al., 2013). The average age of the participants for the survey was 68 years, and 64% of them were women (Forsman et al., 2013). The focus groups' participants consisted of eight women and three men, with an average age of 76 years (Forsman et al., 2013). The researchers found that having relationships with long-term friends and family allowed older adults to experience social support, sense of security, and "shared life events" (Forsman et al., 2013, p. 820), which in turn benefited their mental well-being. The context, which in this case was the nursing home for some participants acted as a facilitator for developing their social relationships (Forsman et al., 2013). In addition,

they found that being continuously involved in “meaningful” activities resulted in a “sense of belonging” (Forsman et al., 2013, p. 18), which also impacted overall mental well-being.

Zunzunegui et al. (2004) conducted a study to determine the associations between self-rated health and social networks and integration of older adults over 65. The study was conducted on individuals from two French-speaking Canadian communities: Moncton and Hochelaga-Maisonneuve (Zunzunegui et al., 2004). These two communities were very different in regards to population size, socioeconomic status, and dominant languages to just name a few (Zunzunegui et al., 2004). Data was collected from surveys conducted in 1995 in both of these cities (Zunzunegui et al., 2004). Moncton and Hochelaga-Maisonneuve had a sample size of 1500 and 1518 individuals respectively (Zunzunegui et al., 2004). Zunzunegui et al. (2004) found that self-rated health for Hochelaga-Maisonneuve residents poorer than that of Moncton. In regards to social networks, individuals in both communities who had additional networks had more positive self-rated health (Zunzunegui et al., 2004). Furthermore, it seems that the number of friends, rather than the quality of friends, is more related to poor self-rated health in both communities (Zunzunegui et al., 2004). However, the authors also found that the relationships between social networks and self-rated health are affected by broader contextual factors (e.g. de-industrialization and deprived neighbourhood, the socio-economic status of the residents) in each community (Zunzunegui et al., 2004). Thus there are factors which may act as mediators between social networks and their effect on health (Zunzunegui et al., 2004).

Subramanian et al. (2002) conducted a study to determine the individual and

contextual effects that social trust had on health. Their data came from the Social Capital Community Benchmark Survey conducted in 2000 (Subramanian et al., 2002). They used the ratings of 21, 456 individuals in 40 United States of America communities (Subramanian et al., 2002). Subramanian et al. (2002) found that there was a complex interaction effect in regards to community social trust (as an indicator of social capital) and its effect on self-rated health. High levels of community social trust may positively affect self-rated health in individuals who have high levels of trust, but not necessarily in individuals who have low levels of trust (Subramanian et al., 2002).-Since the study was cross sectional, it is possible that lower health may result in a lower level of trust instead (Subramanian et al., 2002).

Using the same data source, Kim et al. (2006) also conducted another study regarding the effects of bonding versus bridging social capital on the self-rated health of 24, 835 individuals from 40 United States of America communities. They found that community bonding and bridging social capital were associated with a lower likelihood of reporting fair or low health, and that bonding and bridging social capital does seem to provide “protective effects” (Kim et al., 2006, p. 122). At the same time, these positive effects are affected by the race or ethnicity of the individual, as well as the individual’s level of social capital (Kim et al., 2006). Thus Kim et al. (2006) state the importance of the composition of the community being studied, and how this may influence the effects seen by individuals in regards to social capital.

Social capital and volunteering. There is also a body of research on community volunteering programs using social capital theory. For example, Buys, Marler, Robinson, Hamlin, and Locher (2010) used social capital theory to develop a home-delivered meals

program for older adults. They mobilized the existing social capital in the community which were volunteers in faith-based communities, to develop a new Meals on Wheels service for older adults in a neighbourhood in Birmingham, Alabama (Buys et al., 2010). The result was a successful and sustainable program which consistently delivered meals via volunteers to older adults and is still running at the time the article was published (Buys et al., 2010). This study emphasizes an importance of collaboration between community organizations which initially were derived for one purpose (i.e., faith-based organizations) but used their resources to aid others (i.e. Meals on Wheels program), to expand and create new social capital in the community (Buys et al., 2010; Coleman, 1990). In this sense, the study provides an example of how an organization such as the hospital, though built for different purposes, may help develop social capital through volunteering. For this study, I aimed to find out what factors facilitate and hinder such a process among older volunteers at hospitals in a Southern Ontario community hospital network.

Similarly but in a more rural context, Burnett's (2006) study portrays how a community sport club initiative in the rural village of Tshabo in South Africa created various types of social connections, which led to develop an active community as a whole. Pre-, mid- and post-impact focus groups were conducted, along with 18 interviews on stakeholders (Burnett, 2006). Participants included community leaders, household representatives, coaches and administrators, and participants in the sport program (Burnett, 2006). Burnett's (2006) results found evidence of bonding, bridging and linking social capital throughout the community. For instance, the coaches were all volunteers, many of which were previously unemployed (Burnett, 2006). By becoming part of the

sports program these individuals were viewed by the community as important human resources (Burnett, 2006). This study illustrates how the development of social capital between various members and groups of a single community is beneficial to them (Burnett, 2006). The development of a program to serve the needs of specific community members can influence social capital development within the entire community.

Darcy, Maxwell, Edwards, Onyx, and Sherker (2014) conducted a qualitative study focused on an Australian nationwide non-profit sporting organization called Surf Life Saving Australia (SLSA). Specifically, they examined the bonding and bridging social capital developed in this sporting organization and the effects that these social capitals may have had on the organization (Darcy et al., 2014). The SLSA has nationwide local clubs that are well-known in their communities (Darcy et al., 2014). These clubs have both a sporting and volunteer component (Darcy et al., 2014). The researchers conducted eight focus groups (in both metropolitan and rural locations) in the four states with the largest SLSA membership (Darcy et al., 2014). The 63 people, including SLSA staff, volunteers, and board members, participated. The participants' age ranged from 18 to 70 years (Darcy et al., 2014). The SLSA participants also shared common social and citizenship values (Darcy et al., 2014). Darcy et al. (2014) found a strong theme of "belonging" in the club, which related to the development of strong bonding social capital between club members (e.g. feeling connected through common activities). The individual-level benefits of the SLSA included new skillsets (e.g. teamwork and leadership skills) which they could use outside of the club environment (Darcy et al., 2014). In addition, participants reported some community-level benefits such as public education on surfing safety and community access of SLSA facilities (Darcy et al., 2014).

The bridging social capital found in this study included relationships between the SLSA clubs and other community organizations (Darcy et al., 2014). Lastly, Darcy et al. (2014) found that the bonding social capital developed in the SLSA clubs were able to pave the road for participants, while human capital such as the skillsets they learned, was used to help develop bridging social capital into their community and with other organizations.

Peachey, Bruening, Lyras, Cohen, and Cunningham (2015) conducted a study on a large sport-for-development (SFD) event to determine how it contributed to the development of social capital in its volunteers. Peachey et al. (2015) used a qualitative approach with focus groups, personal interviews, and observation methods. They found that participants were able to build and sustain relationships, especially with people they were unfamiliar with (Peachey et al., 2015). Furthermore, the study found that participants were able to build these relationships, to different degrees, with individuals who were within and outside of their current discipline (Peachey et al., 2015). Through building bridging relationships outside of their discipline, volunteers could expand their knowledge and skills, gaining resources, and engaging in learning (Peachey et al., 2015). Peachey et al. (2015) also found that participants who received benefits from volunteering, felt a greater motivation to continue volunteering in non-profits and for social change in order to help others, which led to further social capital development. Moreover, Peachey et al.'s (2015) study found that there was an influence of the context (e.g. volunteering setting) on the development of social capital. They found that the positive environment helped to facilitate experiences such as learning, but also negative environment (e.g. a lack of organizational support to help volunteers develop those connections) hindered the development of social capital (Peachey et al., 2015).

These studies provide examples of how volunteering created various types of social capital at the individual level (Burnett, 2006; Darcy et al., 2014; Peachey et al., 2015). For this study, I aimed to find if similar occurrences are happening among older volunteers, and what factors facilitate or hinder the process of creation of social capital among older volunteers at hospitals.

Critiques of social capital theory. Although the concepts advocated by social capital theory are useful as an analytical framework for this study, I am also aware that there are some critiques against the theory. Haynes (2009) states eight critiques of social capital theory, four of which relate directly to this study.

The first critique is that “Social Capital is not an explanation but rather a tautology” (Haynes, 2009, p. 9). Haynes (2009) goes on to say that explanations of social capital “begin with the effects of social capital and describe the differences between positive and negative examples in terms of the way social capital has been responsible for producing these effects” (p. 9). Thus social capital theory does not explain why social bonds are created or why social networks exist, rather it restates the differences between the positive and negative effects of these social bonds and networks (Haynes, 2009).

The second critique is that “Changes in social capital and changes in communities, even if they are related, it is difficult to show which direction causality originated” (Haynes, 2009, p. 10). It is unclear whether the development of social capital creates changes in the community, or whether changes in the community help develop social capital (Haynes, 2009). Haynes (2009) notes that several studies have tried to determine this causal relationship, however were unable to. I attempted to determine which direction causality originated in this research study, however I focused instead on

changes in the hospitals which affected the surrounding community.

The third criticism is that “Social capital is difficult enough to define, but it is impossible to measure” (Haynes, 2009, p. 11). Haynes (2009) states that there are both methodological and empirical limitations to accurately measuring social capital. At the same time, the nature of this qualitative research study meant that rather than focusing on measuring social capital, I looked at how social capital and its development was perceived by older volunteers. Rather than trying to measure social capital, I attempted to understand how it affected the experiences of older volunteers, taking into account that social capital cannot be measured.

The fourth criticism is that social capital “can be a hindrance to economic success, with different types of negative externalities, barriers to meritocratic and efficient decision making. Social capital has a dark side” (Haynes, 2009, p. 13). Field (2008) suggests that there are negative connotations associated with social capital, such as when the social capital is generated through being part of a criminal gang. In addition, he suggests that since social capital networks are unevenly distributed, some individuals’ networks are much more valuable to them than others, resulting in the development of inequality (Field, 2008). For this research study, it was possible that by focusing on older volunteers who were active volunteers, the findings were indicative only of the social networks created by this group in relation to the hospital and surrounding community. As a result, older volunteers who do not volunteer as frequently, or older adults who are unable to volunteer due to various barriers, may not be able to have or benefit as much from these social networks.

There are several critiques of social capital theory (Haynes, 2009). I am aware of

these critiques, thus the study is designed so that some of these critiques were fulfilled from the findings in this research. As a result, I cautiously used social capital theory as the analytical framework for this study. The following section will tie together the literature in this chapter, and focus on the emerging knowledge gap.

Bridging the Knowledge Gap

Overall, the literature shows that older adults throughout Canada and Ontario are engaging in formal or organized volunteering in communities (Vézina & Crompton, 2012). Ontario has a slightly higher volunteer rate for older adults when compared to Canada (Cook & Sladowski, 2013). The general trends suggests that, as individuals age, they are less likely to volunteer however the commitment of those who do volunteer increase in terms of hours (Vézina & Crompton, 2012). Older adults were also likely to be “top volunteers” when compared to other age groups (National Seniors Council, 2010).

Nevertheless, it is noteworthy that organizations in Ontario have noted that there has been an increase in older adults leaving the volunteer labour force (Volunteer Canada, n.d.). In addition, of those older adults who are engaged in volunteering in Ontario, only 3% volunteered in hospitals, which is in comparison to 19% of all volunteers who volunteered for health-related organizations (Cook & Sladowski, 2013; Volunteer Canada, n.d.). This study attempted to explore the reasons as to why there was such a small percentage of older adults who volunteered at the hospital.

Another reason why this research study focused on older volunteers in hospitals is to challenge the perception by the general public, which tends to view “older adults” as only a burden to the Canadian healthcare system and society as a whole based on the “apocalyptic demography scenario” (Robertson, 1997). The research project came from

an asset-based viewpoint to determine if and how older adults are contributing back to the healthcare system through their volunteer activities. Previous studies found that organizations have benefited from having volunteers through decreased financial costs, increased quality of care, and social networks and connections made to the patients, their families, and the surrounding communities (Darcy et al., 2014; Handy & Srinivasan, 2004; Handy & Srinivasan, 2005; Rogers et al., 2013; Peachey et al., 2015).

In order to build on the previous studies, this research also explored the development of social capital by older adults as a result of engaging in volunteering. The literature has found that volunteers, through creating these social networks, play an integral role in an organization's relations with their "consumers" and the surrounding community (Darcy et al., 2014; Handy & Srinivasan, 2004; Rogers et al., 2013; Peachey et al., 2015). In addition, older adults can make social networks and connections (i.e. social capital) among themselves through their volunteer work, which has been shown to increase personal well-being, improve social engagement, and allow individuals to engage in the active aging process (Buys et al., 2010; Burnett, 2006; Gilmour, 2012; Forsman et al., 2013; McMunn et al., 2009; Nyqvist et al., 2013; Wahrendorf et al., 2006; WHO, 2002; WHO, 2007; Zaninotto et al., 2013). Concurrently, there is a shortage of literature on how older adult volunteers in particular, create social networks and bonds within hospital settings. As such, there is a lack of literature on the benefits received by older volunteers themselves, hospitals, and the surrounding communities as a result of these social networks and connections created through this form of social participation. Thus for this research, in order to analyze what type of social networks and bonds are formed, how they are formed, and what factors facilitate and hinder their development at

the individual and organizational level, social capital theory (Coleman, 1990; Putnam, 2001), was used as an analytical framework.

Given the benefits of community volunteering at individual, organizational, and community levels, formal volunteering as a form of social participation and engagement among older adults, will be a means to promote active aging and creation of an age-friendly community (PHAC, n.d.; WHO, 2002; WHO, 2007; WHO, 2009). The social bonds created by older adults connect individuals in their communities with the local healthcare system and as a result, improve the well-being of the community as a whole (PHAC, n.d.). However, there is a deficiency in the research which directly examined older adults' volunteerism in hospitals from an age-friendly community perspective. Therefore, the results of this research study were discussed in a larger context to promote the development of an age-friendly community.

This study focused on a specific region in Southern Ontario, as its older adult population is increasing, and is expected to continue increasing in the near future ([Region Name], 2014a). Moreover, the research conducted by the region on how to best help older adults age well in their community, states that issues such as social isolation, and the need for additional social interaction, and volunteering opportunities are some of the key areas that need to be targeted ([Region Name], 2014b). By promoting volunteering at the local hospitals, it is possible to help mitigate these areas of concern ([Region Name], 2014b). As this region is also taking the initiative to turn their community into an age-friendly community, this study was conducted to understand how older adults volunteering in the region's hospital network helped this age-friendly community grow ([Region Name], 2014b). Thus this research project will attempt to

illuminate this gap by focusing on volunteerism in the same organization (i.e. the community hospital network in Southern Ontario), for the same age cohort of volunteers (i.e. older volunteers aged 65 and over). Figure 1 provides a visual depict of this literature review, including the gaps in literature that were found. The following chapter will describe the qualitative methodology and methods used for data collection for this study.

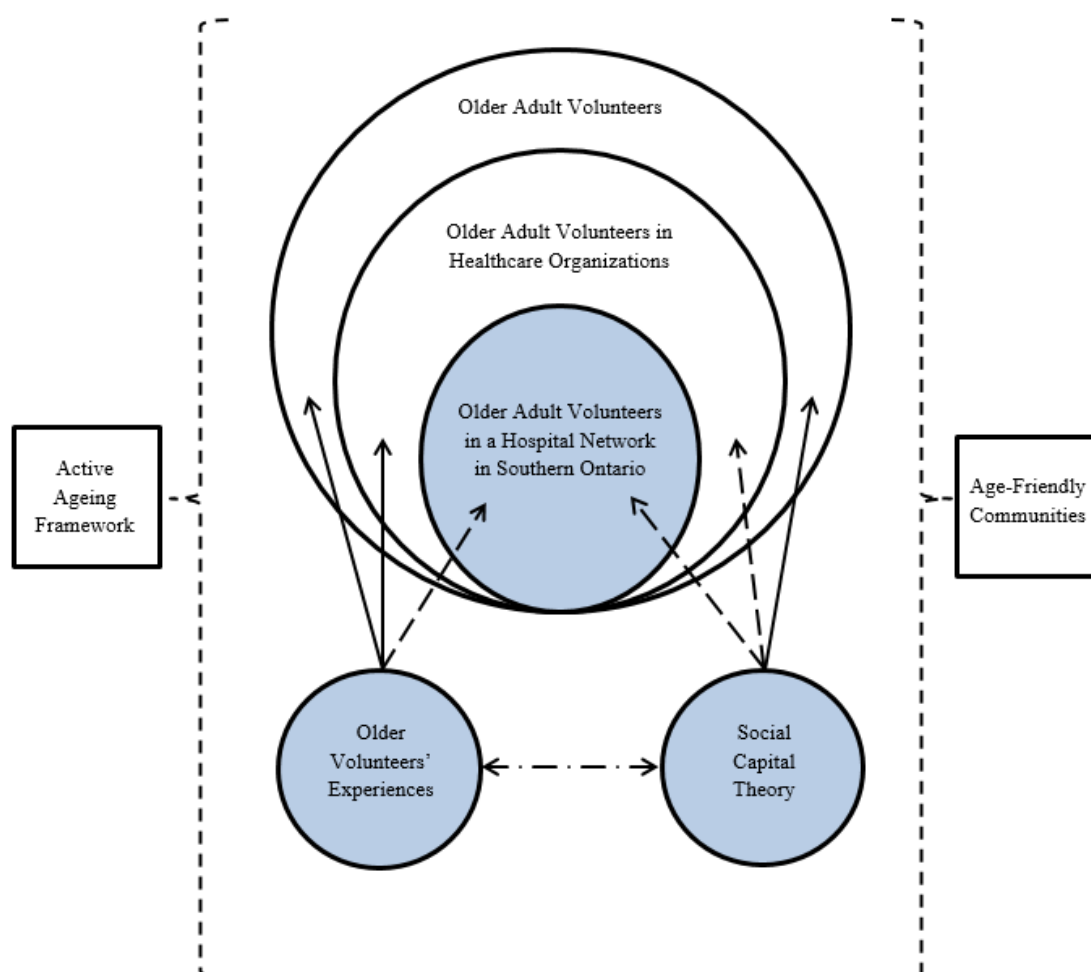


Figure 1. Literature map. This literature map presents a visual diagram of the connections between the areas of interest regarding this research project. The dotted lines represent the areas which are deficient in the prior research, while the solid lines depict areas for which research has been conducted. The blue circles are the main areas of interest for this research, particularly, the older adult volunteers in a community hospital network in Southern Ontario. Specifically, I focused on the older volunteers' experiences and development of social capital in these hospitals. The line with alternate hyphens and dots, represents a gap in exploring how older volunteers' experiences affect social capital and vice versa. These areas of interest were examined using social capital theory as the main theoretical framework. The rapidly aging population and ageism represent the somewhat negative context of the general public's views on the aging population. The research as a result was explored in the context of a more positive view through promoting Active Ageing and Age Friendly Communities.

Purpose of Study and Research Questions

The purpose of this study is to explore the views about volunteerism among older adults within a community hospital network in Southern Ontario, from the older volunteers' perspectives. The following two research questions guided this study:

1. What are the experiences of older adults volunteering in the community hospital network? The main areas that were explored for answering this question were the motivations and perceived barriers for older adults to volunteer, benefits of having older adults in hospitals for both older adults and hospitals, and volunteer management strategies used by the hospitals for older volunteers.
2. Does volunteering help develop social capital for older adults and if it does, how? For this question, I focused particularly on the types of social capital created and maintained by older volunteers, the social relationships between older volunteers and other individuals, the perceived importance and benefits of social capital, and factors that facilitate and hinder social capital.

Chapter 3: Methodology and Methods

The purpose of this study is to explore volunteerism among older adults (aged 65 and over) in a community hospital network in Southern Ontario. There are two objectives for this study. The first is to examine the experiences of older adults' volunteering in the six hospitals in this network. The second is to examine if and how volunteering helps develop social capital for older adults. The findings are discussed within the broader context of promoting active aging and age-friendly communities. This chapter presents the design of the study, the methodological approach, participant selection, data collection and analysis, trustworthiness, and ethical issues.

Design of the Study

This study employed a qualitative research method, in particular, a case study approach. Merriam (2009) notes four key characteristics of qualitative research. The first is that it focuses "on meaning and understanding" (Merriam, 2009, p. 14). Qualitative researchers are interested in how individuals perceive their worlds and attach meaning and interpretation to it (Merriam, 2009). The second characteristic is that the primary instrument for data collection is the researcher (Merriam, 2009). As understanding the participants and their world (i.e. their experiences and its meanings) is the main goal of qualitative research, the researcher as a data collection instrument, should gather the data through direct communication with the participant (Merriam, 2009). The third characteristic is that qualitative research is generally an inductive process (Merriam, 2009). Data is collected and analyzed into numerous categories and themes, which result in the development of new concepts and theories regarding the phenomenon being studied (Merriam, 2009). The fourth characteristic of this field is the richly descriptive

product that results from the data collection and analysis (Merriam, 2009). Qualitative research can produce detailed findings from data collected through a variety of methods such as in-depth interviews, document analysis and field notes (Merriam, 2009).

Within the field of qualitative research, there are several interpretive and theoretical frameworks that could be employed by researchers, along with philosophical assumptions which underlie the framework to be used (Merriam, 2009). This research project employed a social constructivist framework. Social constructivism focuses on the subjective meanings of individuals of the world in which they live, and constructed intersubjectively with others (Berger & Luckmann, 1966). It encourages the discovery of multiple perspectives and focuses on the processes involved in interactions (Berger & Luckmann, 1966; Creswell, 2013). Ontologically, this framework focuses on relativism rather than realism (Creswell, 2013; Merriam, 2009). Researchers using this framework believe that there can be many realities constructed, thus this framework focuses not on finding the so-called “truth”, but on the meanings of these realities (Creswell, 2013). These realities are dynamic and are constructed from an individual's perception of an event (Merriam, 2009). Within social constructivism, the researcher positions herself in the study and draws upon an interpretation of the findings partially based on her own experiences (Creswell, 2013). As such, the epistemological belief of social constructivism is that knowledge is socially constructed, subjective and co-created with both the researcher and participant (Creswell, 2013). As I brought my own values into the research, the axiological assumptions are that these values are honoured in the findings (Creswell, 2013).

The social constructivist framework is directly applicable to this research project

as this study focused on understanding the volunteer experience and development of social capital, through older adults' volunteering in the community hospital network in Southern Ontario. I focused on the multiple realities and meanings constructed by the 10 older volunteers and interpreted these findings referring to social capital theory. By including reflexivity in my research process and writing, I acknowledged my own perceptions and the role I played in creating these realities. The next section will outline the methodological approach that was used for this project.

Methodological Approach

This research used a qualitative case study approach. Though there are several definitions of a case study, Merriam (2009) notes that “a *case study* is an in-depth description and analysis of a bounded system” (p. 40). The case study can be confused with being a method, methodology or research design (Liamputtong, 2009; VanWynsberghe & Khan, 2007). Merriam (2009) expands on this point by stating that the case study can be the process of conducting the research, the actual unit of analysis, or the product of the research study. I used the term *case study* as a methodological approach which centers on the unit of analysis in a bounded system (Creswell, 2013).

The most distinct feature of the case study is the examination of a “bounded system” (Merriam, 2009). This bounded system provides a fence around a unit, which can be a person, program, system or phenomenon (Merriam, 2009). In this study, the case is the 10 older adult hospital volunteers in the community hospital network in Southern Ontario. This bounded system includes the older volunteers in six hospital sites across the community hospital network. The case is bound through geographic location (i.e. Southern Ontario), the type of healthcare organization (i.e. hospitals), and the target

groups (i.e. older volunteers, hospital staff, and people in the surrounding communities who use these hospitals). The case is also temporally bounded as the research focused on the current state of the hospital network, and how the recent and ongoing changes since its amalgamation 15 years ago, have been affecting the volunteers' current experiences in the hospital.

Baxter and Jack (2008) note that case studies are better used when one wants to examine a phenomenon which would not be comprehensible unless viewed within its particular contextual conditions. In addition, Creswell (2013) notes case studies are used when the researcher wants to obtain an in-depth understanding of a particular situation. I used a case study approach since the goal of this research was to explore the volunteer experiences of older adult volunteers, as well as the development of social capital by these volunteers, within the context of the community hospital network at this specific period in time.

Qualitative case studies are *particularistic*, *descriptive*, and *heuristic* (Merriam, 2009). This single case study is particularistic as it focused on a specific hospital network, and the experiences of older adults who volunteered there as a phenomenon. The study is descriptive as the collection and analysis of data from documents and in-depth interviews with older volunteers resulted in richly descriptive findings. Heuristic refers to the fact that the result of the case study reflects not only to the viewpoints and experiences of the participants and researchers, but also associates the reader's own experiences with the case (Merriam, 2009). This is also called "naturalistic generalization" (Stake, 2007, p. 3 as cited in Merriam, 2009). Depending on the similarities in the contexts, the results of this case study can be used to help other healthcare organizations illuminate their older

volunteers and their social capital for active aging.

There are both single and multiple case studies (Yin, 2009). This research used a single case study design as it analyzed the experiences of older volunteers in the same community hospital network as one case. I recruited 10 participants from six hospitals in the network in order to have maximum variation in the case. Yin (2009) notes that with case studies that are holistic, there is the possibility that the purpose of the research will “shift” and the research questions being answered by the data will be different from the original research questions. This did occur in this research. However rather than a complete change in the original research purpose, there was only a slight modification. I originally planned to compare the views of older volunteers and those of the volunteer administrators. However, after analyzing the data from the first few interviews with the older volunteer participants, I decided to focus on only the 10 older volunteers’ experiences, given the richness of their stories. For this research project, the findings described a holistic picture of 10 older volunteers’ experiences and opinions in the unit – the community hospital network in Southern Ontario – as a whole.

Participant Selection Strategies

Qualitative research focuses on using nonprobability sampling methods (Merriam, 2009). I employed a purposive sampling strategy for this research. Purposive sampling is the most common form of nonprobability sampling and was utilized in order to recruit only the most information-rich participants to obtain an enhanced understanding of the case (Merriam, 2009). According to Merriam (2009), there are two levels of purposive sampling for a case study methodology. The first is the selection of the case which is the bounded system and the unit of analysis, which in this case are the 10 older hospital

volunteers in the community hospital network (Merriam, 2009). The second level of purposive sampling for case study research is used to identify the individuals to be interviewed, sites to be visited and documents to be read (Merriam, 2009). To equally represent the different sub-regions covered by the community hospital network, I recruited 10 older volunteers (who were 65 years and older) from six hospital sites.

Data saturation was also considered when choosing the sample size for the volunteers. Though it is difficult in qualitative research to determine when saturation has been reached, a general guideline is when no new data is being generated from obtaining more cases (Padgett, 2008 as cited in Liamputtong, 2009). Given the limited time and resources for a MA thesis project, I wanted to interview a total of 12 individuals, however only 10 participants were recruited in the end. In addition, I made sure to have at least two older volunteers from each of the six hospital sites when possible, so that I could compare and verify their account. Thus I was able to obtain some overlying patterns from these 10 participants (Liamputtong, 2009; Merriam, 2009; Yin, 2009).

Participant Profiles

There were 10 older adult volunteers in total who agreed to take part in this research study. The participants though were chosen at random from the list provided by two Coordinators of Volunteer Resources in the community hospital network. All participants were female volunteers and over the age of 65. There were seven Auxiliary volunteers, two non-Auxiliary volunteers, and one individual who had both Auxiliary and non-Auxiliary roles. There were six participants who were married or living with their partner, two who were widowed, one who was single, and one unknown. Many of the participants spent over five hours per week in the hospital for their volunteer position,

and five individuals spent over 15 years volunteering in the hospital. Moreover, eight out of the ten participants stated that they had other volunteer commitments outside of their hospital volunteering. Table 1 provides additional details on the participants' profiles:

Table 1

Participant Profiles

Participant #	Name	Marital Status	Age	Auxiliary or Non-Auxiliary	Hours Spent in Hospital Volunteer Position ^a	Years of Volunteering		Other Volunteer Commitments ^b
						In the Hospital	In General	
1	Shelia	Married/Living Common Law	65 or over	Auxiliary	Over 10 hours per week	Approximately 15 years ago	N/A	Yes (Few)
2	Elizabeth	Widowed	65 or over	Both	Over 8 hours per week	Approximately 4.5 years ago	N/A	No
3	Lianna	Married/Living Common Law	70 or over	Auxiliary	Over 10 hours per month	Since 23 or 24 years old	Since 15 or 16 years old	Yes (Many)
4	Wendy	Married/Living Common Law	80 or over	Auxiliary	Over 10 hours per week	Approximately 25 years ago	N/A	Yes (Many)
5	Alice	Married/Living Common Law	65 or over	Non-Auxiliary	Over 7 hours per week	Approximately 20 years ago	N/A	Yes (Few)

6	Meriam	Married/Living Common Law	65 or over	Auxiliary	N/A	N/A	N/A	Yes (Many)
7	Georgia	Unknown	65 or over	Non- Auxiliary	Less than a full week	Approximately 2 years ago	N/A	Yes (Many)
8	Florence	Single	80 or over	Auxiliary	Over 14 hours per month	N/A	N/A	Yes (Few)
9	Clarissa	Widowed	80 or over	Auxiliary	N/A	Auxiliary member for 20 years	N/A	Yes (Few)
10	Amanda	Married/Living Common Law	75 or over	Auxiliary	N/A	Started in 2004	Volunteered most of her life	Yes (Unknown)

Note. ^aThe number of hours spent in the participant's volunteer role is a summation of the hours spent in all of the participant's current volunteer roles, where possible. I made some assumptions when the number of hours given were vague.

^bI also made assumptions on the number of volunteer positions based on the data. If participants seemed to have four or more other volunteer positions, "many" is typed into the brackets. However, if participants seemed to have less than four other volunteer positions, "few" is typed into the brackets.

Data Collection

Data collection was divided into three phases. The first phase, which consisted of document analysis, was the preparation phase before the fieldwork began. The second phase consisted of one-on-one interviews conducted with two volunteers (when possible) from each of the six hospital sites. The third phase consisted of a one-on-one interview with a key informant for this research. The following figure is a visual depiction of the three phases of data collection.

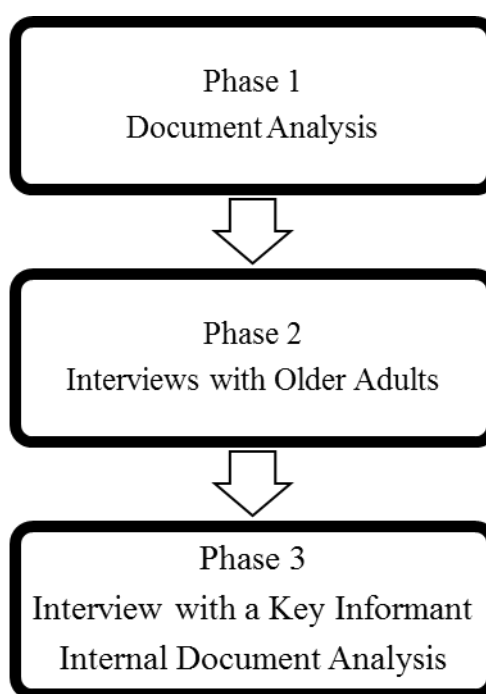


Figure 2. Data collection phases. This figure illustrates the three phases of data collection.

Phase 1: Document analysis. The first phase of this project was the analysis of the community hospital network's documents in relation to volunteering, which are available to the public via the network's webpage. The purpose of this document analysis

was to determine what information is available on the volunteer program in the community hospital network, such as the number of volunteers who are in the network, to obtain contact information for any hospital administrators, and to use this data to modify interview questions to cater to this particular case.

Merriam (2009) states that “documents” are usually not produced specifically for the research question, compared to other forms of data such as interviews. As a result they are unaffected by the presence of the researcher and are an easily available source of data (Merriam, 2009). In addition, as these documents were created by and are the property of the community hospital network, I am aware that these documents may contain built-in biases. For instance, the documents may only provide positive statistics about the volunteer program.

In total, there were three documents that were available through the community hospital network’s webpage on volunteer resources and used by me for this study. These included:

1. Volunteer Resources 2013 Impact Statement;
2. Volunteer Handbook;
3. Volunteer Application Form.

The first document contained information on some of the benefits of having volunteers in the community hospital network, general statistics on the volunteers such as age distribution, data on volunteer satisfaction, and some information on new projects related to engaging volunteers. The second document provided volunteers with guidelines and rules for volunteering at the community hospital network. In addition, the Volunteer Handbook provided information on the six hospital sites. The third document was an

application form for potential volunteers. In addition to these documents, I also used information found on the community hospital network's website to help understand and write a detailed case description for this study. This included general information on six hospital sites and their respective Auxiliaries (will be further discussed in Chapter 4).

Phase 2: Interviews with older volunteers. The second phase of data collection consisted of interviewing older adult volunteers at each of the six hospital sites in the community hospital network. Specifically, I attempted to interview two active volunteers at each hospital site. The purpose of these interviews was to explore volunteerism among older adults in the community hospital network from the older volunteers' perspectives.

List of potential older volunteer participants. In order to recruit the older volunteer participants, I asked two Coordinators of Volunteer Resources at the community hospital network if they could provide me a list of 30 older adult volunteers to be interviewed in Phase 2 of data collection, through asking for their permission to put their names, contacts, and information on their volunteer hour contribution (if available) on this list. As there were two Coordinators of Volunteer Resources in charge of different hospital sites in this network, I asked for the assistance of both of these individuals for the project. In order to minimize the feelings of pressure to participate in the study among the older participants, I asked the Coordinators of Volunteer Resources to list only those who were interested in participating in the research study voluntarily. I also asked the Coordinators of Volunteer Resources to get an oral consent from those who were willing to be listed on the recruitment list, to have their information forwarded to myself.

The study projected to have two volunteers per hospital site. These older adults, who were active volunteers may have had much more experience in volunteering at the

hospitals. Thus these volunteers were information-rich cases. I asked the Coordinators of Volunteer Resources to provide a list of at least five volunteers per hospital site. I was provided with a final list of 38 potential older volunteer participants. Some of the hospital sites in the network had less than the five potential participants who were interested, and other hospital sites had greater than five potential participants who were interested. I then randomly chose two participants from the list at each hospital site to interview.

Recruitment strategy. Using the contact information provided in the list of 38 potential volunteer participants, I randomly chose two participants from each hospital site to interview. These participants were active volunteers. As I had no prior connection to any of the volunteers in this community hospital network, I emailed, or phoned the potential participant, depending on the contact information provided by the Coordinators of Volunteer Resources (See Appendices A and B). They were also sent a Letter of Invitation to the study (See Appendix C). A follow-up phone call was made in a few cases to see if the individual wanted to participate (See Appendix D), and an Informed Consent Form and a copy of the interview guide (See Appendices E and F) was sent to them if they agreed. In the case that they did not agree to participate, I contacted another individual from the list provided by the Coordinators of Volunteer Resources, to ask if they would like to participate in the study.

Data collection strategy. I conducted an in-depth semi-structured interview with each participant using an interview guide (See Appendix F). Appendix F contains the interview guide with some probing questions, which were needed during interviews to gain in-depth information on certain areas of interest (Liamputtong, 2009). The guide was developed based on the literature review in Chapter 2. The main areas of the questions for

the older adults included: (a) motivations and barriers to volunteering for older adults; (b) benefits and challenges of having older volunteers in the hospital; (c) how management strategies such as those used for recruitment and retention are seen by participants; (d) development of social capital as a result of volunteering.

In order to allow participants some time to consider the questions being asked, especially because it involved some reflection on their own volunteer experiences, the interview guide was sent one week in advance of the interview date. The interview was conducted at the place and time requested by the participant, however I did make a request for the interview to be held in a location with minimal noise. All of the interviews ended up being conducted in the participant's home except for one participant, whose interview was conducted in a secluded public library space on the lobby floor of their apartment complex. Each interview was audio-recorded and took approximately one and a half to two hours.

Once each interview was conducted, it was transcribed verbatim (including pauses, tone of voice, etc.) in order to analyze the data presented in the interview in its exact form (Liamputtong, 2009). The interview contained conversation style, as well as emotional expressions captured by the recorder, which I analyzed while transcribing it verbatim. The computer software Express Scribe was used to transcribe the interview. I then read and re-read the printed copy of the transcription to ensure that there were no transcription errors (Liamputtong, 2009). Afterwards, I emailed or mailed a hard copy of the transcription to each participant for *member checking*. Through this opportunity, each participant had a chance to check the accuracy of their interview transcript as well as change or delete some of the contents if they so desired. If I did not hear back from the

participants one week after mailing the transcript, I followed up with a phone call to ensure that the participants gave their consent for the use of the transcript for the study. If they did not respond to the call, I then assumed the transcript was ok to use the way it was.

Phase 3: Key informant interview. The third phase of data collection consisted of a one-on-one in-depth interview with one key informant. This key informant was considered to be an information-rich individual as that person was very knowledgeable about the volunteer program and older volunteers in the community hospital network. Information-rich individuals are knowledgeable about issues related to the purpose of the research, thus allowing researchers to learn from them (Patton, 2002 as cited in Merriam, 2009). The main purpose of this interview was to obtain further information and clarification regarding the points that emerged from the interviews with older volunteers, in terms of volunteers' conditions in the hospitals and ongoing structural changes in the community hospital network. The secondary purpose of this interview was to obtain any internal documents with information on the volunteer program and volunteer statistics that were not provided from the public documents in Phase 1. As this individual provided information on the overall conditions of volunteering in the community hospital network, this individual was considered to be the "key informant" of the study.

Recruitment strategy. The community hospital network's Research Ethics Board required the inclusion of at least one internal staff of the community hospital network in the research team. Hence I visited the one of the community hospital network sites to meet potential collaborators in the early stage of this research in order to explain the research purpose, and ask for their collaboration with the research. One of these

individuals kindly joined as an internal co-investigator for the community hospital network. I promised that I would get back to this individual after finishing the interviews with older volunteers. Therefore, I sent an email to this individual to give an update on my research, explain the modifications, and ask if this person was interested in participating in the study as a “key informant”. An initial email, Letter of Invitation, Informed Consent Form and a copy of the Interview Guide (See Appendices G, H, I and J) were sent to the key informant who agreed to participate.

Data collection strategy. I conducted an individual semi-structured interview with one key informant using an interview guide which contained probing questions to obtain more detailed information (See Appendix J). The guide was developed based on the responses obtained in the older volunteer participants’ interviews. The main areas of the questions for the key informant included: (a) volunteer trends in the hospitals; (b) management strategies such as recruitment, training, and retention; (c) Auxiliary volunteers; (d) uniqueness of hospital volunteering and barriers; and (e) hospital condition and change.

I sent the participant a copy of the interview guide (See Appendix J) two weeks before the interview as the key informant needed some time to prepare for questions that were specifically about older volunteers and their volunteer conditions in the community hospital network. In order to decrease the length of time of the interview, the key informant provided me with a document containing lengthy responses to some of the interview questions a week before the interview. I then used this document to modify and delete some of the questions from the interview guide. The interview itself was conducted in the place and at the time requested by the key informant. In addition, I made a request

so that the interview was conducted in an area with minimal noise. The interview took approximately two hours, and was audio-recorded.

The data from the key informant interview was kept as an audio file, and not transcribed verbatim. As this interview was used only for obtaining a further clarification of the information found from Phase 2, only key pieces of information (e.g. information that adds depth and detail to the findings from participants' interviews) was typed into bullet format on a Word document. The computer software Express Scribe was used to assist in typing up this document. I then read and re-read the printed copy of the document to ensure that there were no typing errors (Liamputtong, 2009). Afterwards, I emailed a copy of the typed document to the key informant *for member checking*. Through this opportunity, the key informant had a chance to check the accuracy of the typed document as well as to change or delete some of the contents as desired.

Internal documents. I requested internal documents from the key informant in order to add more descriptive detail to the case study context. Specifically, this was to request information which was not already available through the Phase 1 document stage. The two internal documents obtained from the key informant and used in the findings were:

1. Volunteer Resources – Annual Impact Statement;
2. [Community Hospital Network Name] – Forward – Annual Report 2014/15.

The first document contained information on the Auxiliaries in six hospitals in the network. The second document contained information on the community hospital network in general including the services available at each of the six hospitals. Merriam (2009) states that documents may have detailed information about programs and practices,

which may not necessarily be revealed during in-depth interviews. For this research project, the new information obtained from the internal documents were used to add depth and description to the case study.

Data Analysis

Data analysis for qualitative research is basically inductive and emergent (Merriam, 2009). Merriam (2009) states that data analysis should occur simultaneously with the collection of data, and will allow the researcher to modify her interview questions by adopting new questions emerged through previous interviews in order to expand the scope of discovery. The following section on data analysis for this study drew mainly from Merriam's (2009) procedures for case study analysis. First, I will explain the specific strategy used to analyze qualitative interview data (i.e. category construction and conceptualization). Then, I will provide an overview of my three stages of data analysis procedures for the three different sources of data.

Category construction. Merriam (2009) describes data analysis of qualitative research as the process of category construction. It is an inductive process and continuously modified, through the constant comparative method, as the researcher finds new data which can be added into the group (Merriam, 2009). Categories can be defined as abstract concepts which cover specific segments of data (Merriam, 2009). These categories will eventually become quite defined and will represent specific patterns that may occur throughout the data (Merriam, 2009).

The category construction process involves two levels of coding, *open coding* and *analytical coding*, noted by Merriam (2009). Coding is when the researcher assigns some sort of notation to the data in order to easily access it for analysis (Merriam, 2009). The

process of coding began once the first interview was transcribed (Merriam, 2009). I first printed out a hard copy of the transcript and noted any potential segments of the raw data in the transcript that may have some relevance to the study, thus starting the *open-coding* process (Merriam, 2009). I then went through each transcript line-by-line and by hand colour-coded all segments of data that had some sort of meaning (Merriam, 2009). In this phase of coding the segments of data from the interviews were assigned codes. These codes were written in the margins of the transcript and then made into a long list. The second stage of coding is where I sorted these codes into groupings, and refined these groups into categories by hand. This process is known as *analytical-coding* (Merriam, 2009). This stage of coding focuses on sorting and refining the codes that emerged from open coding, in order to develop a list of categories and sub-categories based on meanings and interpretations of the data (Merriam, 2009). Once codes from the first transcript had been grouped, I moved onto the second transcript and refined the list of tentative groups by hand. At this point I created a more definitive list of concepts which reflected patterns or recurring situations throughout the transcripts. Afterwards, I transferred this list of concepts to NVivo 10 and continued the coding process on this software. I eventually refined and developed a master list of categories on the computer software NVivo 10, to which new pieces of data from the third transcript were added.

Throughout data analysis and the addition of new data, these tentative categories were revised and refined. As the comparison of interview transcripts advanced, the process of adding codes to support the existing categories became more deductive than inductive. At the same time however, I was vigilant to not fail to add new categories when unique and unexpected codes emerged in the transcript. Using Merriam's (2009)

procedures, segments of data were screened against the category's criteria to see if they fit, then were placed into a category accordingly.

Criterion to make categories. Merriam (2009) makes note of several criteria that developed categories should follow. The first is that categories should be created in regards to the research project at hand (Merriam, 2009). Categories are developed in order to understand the purpose of the research study and thus can be considered answers to the research questions (Merriam, 2009). The second criterion is that all the data segments should fit into one of the categories (Merriam, 2009). There should not be several segments of data which are left over once the categories are finalized (Merriam, 2009). To this end, the third criterion is that no segment of data should be able to fit into two categories (Merriam, 2009). Each category should be unique and the sharing of data segments between two categories should not occur (Merriam, 2009). Merriam (2009) also states that the names of categories should accurately represent their collection of data. A reader should be able to gain an understanding of what the category represents from the name alone (Merriam, 2009). The final criterion is that categories should be constructed at one level of abstraction (Merriam, 2009). All categories should be on the same level in value and representation, though some categories may have more data than others (Merriam, 2009). I used these criterion to create and refine the categories from the data.

Conceptualization. Once category construction was complete, the data analysis moved onto the conceptualization phase. In this phase, I started to examine the relationships and interactions between all the categories and sub-categories (Merriam, 2009). This allowed me to describe and visualize the interactions and relationships between all the categories (Merriam, 2009). Through conceptualization, I determined the

interactions and relationships between the categories. I also looked for situations or concepts that did not seem to fit the findings, thus engaging in *negative-case analysis* (Creswell, 2013). By using negative-case analysis, I ensured that the categories and concepts that were found were critically assessed and were reasonable interpretations of the data (Creswell, 2013; Merriam, 2009). From these relationships I then drew meaningful interpretations of the data to describe a holistic picture of the case (Merriam, 2009).

Overview of data analysis. Figure 3 is a visual depiction of the three stages of data analysis. I used the aforementioned category construction and conceptualization strategy to analyze the interview data in Stage 2 of the data analysis process.

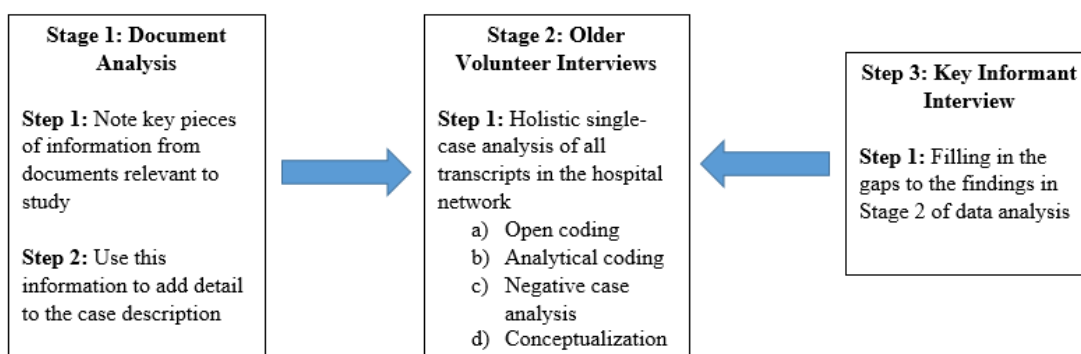


Figure 3. Data analysis strategies for interview and document data. This figure illustrates the three stages of data analysis that will be used for this research study.

Stage 1: Document analysis. The first stage of data analysis was to analyze the documents obtained from both the community hospital network's website, the community hospital network's website itself, and the internal documents provided by the key informant. I analyzed these documents in order to obtain information which may answer some of the research questions such as management strategies, mandatory

training procedures, and demographic information. In addition, the information from the document analysis was used to understand the overall context or background in which the findings from Stage 2 were situated, thus adding depth and detail into the case description.

Stage 2: Older volunteer interviews. There were 10 older adult volunteers in the community hospital network (one to two participants in each of the six hospital sites) who were interviewed. The first step of this stage was holistic single-case analysis, and allowed me to first take one transcript and engage in open-coding and analytical-coding. The NVivo 10 software was used throughout data analysis to help with coding and data management. In the second step, I repeated open and analytical-coding for the second transcript, eventually creating a master list of categories. I then kept refining this list and added codes from additional transcripts. After, I engaged in some negative-case analysis to ensure that the interpretations did come from the data. Lastly, I used conceptualization in order to examine the older hospital volunteers as a whole case and develop overarching concepts and interpretations.

Stage 3: Key informant interview. Only one key informant interview was conducted. As this interview was used only for the purposes of obtaining a more detailed understanding of the Stage 2 findings, there was no need to engage in open-coding and analytical-coding. Instead, I used the data obtained from the typed document to fill in the gaps in the findings found in Stage 2 of data analysis.

Trustworthiness

There are four aspects of qualitative research that researchers have to examine in order to ensure rigor, in other words, the quality of the study or *trustworthiness* (Bryman, Teevan, & Bell, 2009; Liamputtong, 2009). These are: *credibility*, *transferability*,

dependability, and *confirmability* (Liamputtong, 2009).

Credibility. Bryman et al. (2009) define *credibility* as being tied with different interpretations of the world by different individuals. Qualitative research is focused on the multiple realities perceived by the participants, which are constantly changing (Merriam, 2009). Thus credibility is used to ensure that the interpretations and themes obtained from the participants hold true to their interpretations of reality (Merriam, 2009).

Merriam (2009) states several methods can be taken to ensure credibility of the findings. The most known strategy for this endeavour is *triangulation* (Merriam, 2009). This method ensures that multiple sources are used, whether it is multiple sources of data, researchers, methods, or theories, in order to strengthen credibility of the research (Merriam, 2009). This study employed the use of two researchers (myself and my thesis supervisor Dr. Narushima) to analyze the collected data, thus engaging in *investigator* triangulation (Merriam, 2009). In addition, I used data obtained from the interview with the key informant, interviews with the older volunteers, and document analysis, therefore triangulation is also achieved through using multiple data sources. This research also analyzed the data referring to two different frameworks (i.e. social capital theory and volunteer theory), thus engaging in theoretical triangulation as well.

Researchers can also engage in *peer examination* to increase credibility of their study (Merriam, 2009). For this study, I received advice from my supervisor (Dr. Narushima) and two thesis committee members (Dr. Law and Dr. Gardner) throughout the research process. These individuals reviewed the findings and commented on whether my interpretations are reasonable in regards to the data collected (Merriam, 2009).

Transferability. The term *transferability* is used in qualitative research to

describe the ability for a study's findings to be applicable to other situations, outside of the context of the research study (Liamputtong, 2009). It differs from *generalizability*, which is a key requirement in quantitative research and focuses on applying the results from a sample to a population (Merriam, 2009). Transferability rather, focuses on the theoretical assumptions and findings in a study and taking into account the basic context for a different situation, applies the knowledge obtained in order to develop some informed conclusions (Merriam, 2009).

Maximum variation is one method through which the transferability of a study can be improved, through increasing the range of applicability of the findings (Merriam, 2009). This research is a single case study, which are the 10 older hospital volunteers in a single community hospital network in Southern Ontario. However, by including six hospital sites in this community hospital network, I included diverse volunteering experiences in the sub-regions of this area.

Transferability is also ensured through adding *thick, rich description* as part of the findings (Merriam, 2009). In order for the study's findings to be applicable for other similar contextual situations, I provided a detailed description of the data. This in-depth information on the setting, participants, and findings will allow other individuals to apply some of the theoretical assumptions or findings to similar situations.

Dependability. Also known as *consistency*, this aspect of qualitative research focuses on whether the findings of the research fit with the collected data (Merriam, 2009). Qualitative research focuses on the different interpretations of human experiences (Merriam, 2009). As these interpretations are ever-changing, it is difficult to obtain replicable findings of a certain phenomenon (Merriam, 2009). As a result, rather than

focusing on whether research findings can be replicated as in quantitative research, dependability is used to confirm that the study's results are consistent with the raw data (Merriam, 2009).

One method through which dependability can be enforced is by having an *audit trail* (Merriam, 2009). In this method, my notes, papers and documents which relate to either the study or to my own interpretations on the studies, were collected and made available for examination (Liamputtong, 2009). Peers and external auditors could then examine these files during or after the study in order to ensure that the study followed proper procedures and that any inferences made are justifiable by my notes (Bryman et al., 2009). In regards to this research study, notes outlining how the study was conducted and how the results were reached, were recorded and kept in case the thesis committee needed to audit the process. Throughout the data collection process I kept notes on the procedures that were followed on memo notes and during data analysis I wrote down my thought processes and how I reached my inferences from the data.

Confirmability. This term refers to the researcher's own awareness of what she is adding to the data (Bryman et al., 2009). The findings of the study should be able to relate back to the data collected and not solely be derived from the researcher's own thoughts (Liamputtong, 2009). I ensured that I did not modify the findings due to personal reasons or assumptions of the results. At the beginning of the research, I bracketed my own assumptions about volunteering based on my previous experiences by writing these assumptions down. In addition, I kept my notes and thoughts throughout the research project in order to monitor my own subjectivity. I had also made my documents available to audit, in order to confirm that the findings did come from the data collected.

Reflexivity

It is important for the researcher to announce his or her stance on the research being conducted in qualitative research (Merriam, 2009). This allows the reader to understand the views of the researcher, as well as how the researcher may have reached his or her interpretations of the findings (Merriam, 2009). My interest for conducting this study came from my past experience as a very involved formal volunteer. I worked in positions which required me to publicly speak to individuals or groups, and assist them with their questions or concerns. I was able to develop a number of social connections and networks with a number of other volunteers as well as supervisors through these positions, and have had very positive interactions with both. As a result my initial reaction to volunteerism is that of a positive stance. I believe that it does have the potential to benefit the physical, mental, and social health of an individual. I am aware of my own bias and was cautious of the potential risk that I put more focus into the positive aspects of volunteerism than the negative aspects. Nevertheless, it was imperative that both positive and negative aspects of volunteerism were examined as they are important in describing the environment and conditions in which volunteerism occurs in organizations.

Ethical Issues

Research Ethics Board (REB) approval. An application was submitted to Brock University's Research Ethics Board as well as the Research Ethics Board of the community hospital network in Southern Ontario. There were some minimal risks for the participants in this research project.

There were psychological and social risks for the older volunteer participants. In

regards to the older adults, since the Coordinators of Volunteer Resources provided the list of potential participants, the older volunteer participants may have felt psychologically pressured into talking about positive aspects of their organization and the volunteer program. There may have been social risks in regards to the reputation of the older volunteer participants. For example, the volunteers' boss may not have liked what the volunteers told me, and what I reported in the findings. As a result, it may ruin the reputation of these volunteers in the hospital, and may result in unfair treatment of them from their boss and fellow volunteers. In addition, as the volunteer participants were older adults, it is possible that they may have felt obligated to answer all the research questions in the interview to help me as the student researcher.

There was also the possibility for psychological and social risks for the key informant. The key informant, who is the employee of the hospital, may have felt psychologically pressured into talking about positive characteristics of the volunteers and the organization. In addition, the organization or the boss of the key informant may not have liked what this individual told me as the researcher, and what was reported in the findings. This may cause potential conflict between the boss and the key informant, and may ruin this individual's social reputation in the organization. Thus there was a social risk for the key informant for participating in the study.

Informed consent. The informed consent process was very similar for the older adult volunteers, and the key informant. I first sent all the participants (older adults and key informant) the initial email of invitation (See Appendices A and G), an initial phone call to older adults if an email was not sent (See Appendix B), and the follow-up phone call (See Appendix D) to determine whether the individual would have liked to

participate in the study. I made contact with the individual for the research study only if the individual agreed to participate in the study. In addition, for recruiting older volunteers, I asked the Coordinators of Volunteer Resources to first give the older volunteers just a brief outline of the study, and if they wished to know more or potentially participate, to get an oral consent to pass their contact information on to myself as the researcher.

After I contacted the participants to schedule the time and specific location for the interview, I sent all participants the consent form (See Appendices E and I) and interview guide (See Appendices F and J) for the study one week (two weeks for the key informant) before the interview was conducted. In the “Letter of Invitation”, “Consent Form”, and the “Interview Guide” (See Appendices C, H, E, I, F, J) all participants were informed and assured that participation in the research study was voluntary and confidential, and that they could withdraw from the study at any point in time. In the “Interview Guide” for both the older volunteers and key informant, it was stated that the participant was not obligated to answer any question that made them feel uncomfortable.

On the day of the interview, I brought a hard copy of the consent form (See Appendices E and I) and went over this with the participants before starting the interview, which allowed the participants to ask questions if they had any. I informed the participants again that they could withdraw from the research study at any time without penalties, and explained the minimal risks and measures taken to reduce them, as a result of participating in the research. I also stated that there were no monetary incentives for becoming a participant in this study. I then asked the participants to sign the consent form if they agreed with everything on the form. I kept the consent form page, while the

participants kept the information section of the consent form for their own records, which was signed by both researchers (myself and my supervisor Dr. Narushima).

Once the transcript for each interview was complete, I emailed or mailed a hard copy out to the participants. This way, participants had the chance to go through what they said and determine whether there was anything that they would have liked to have removed, which did happen in some cases. By using this strategy, I ensured that there was complete consent on the information being used for interpretation and anonymous quotation in final documents, presentations, and publications.

Participant confidentiality. All participants were ensured that any data collected (e.g., consent forms, interview recording, transcript, and any other personal information) were kept confidential (Liamputtong, 2009). If the files were on a computer, they were password protected and if they were in print format, they were in a locked cabinet. Only myself and my supervisor had access and listened to the audio tapes from the interviews. The audio tapes were also labeled with a code rather than the participants' identifying information. As well, no information that can identify the person were published in the findings (Liamputtong, 2009). All personal identifiers in the transcripts and final report, such as names or places, were replaced with pseudonyms and general descriptors. If the participants decided to withdraw from the study, all data related to those participants were destroyed immediately and not used in the study. Only I and my supervisor knew of the participants' real name. Confidentiality was especially important for this research study as there were only 11 participants in total (older volunteers and key informant), all of which were from the same hospital network.

In order to increase the confidentiality of the key informant participant, I referred

to this individual only as the “key informant” rather than using that person’s job title. By using this general designation, it was unclear as to which individual in the community hospital network was contacted for this study.

In order to increase the confidentiality of the older volunteer participants, I asked the Coordinators of Volunteer Resources to obtain a list of at least five to six volunteers for each hospital site. By using this method, only I knew which two participants from each of the six hospital sites have participated in the study. This also allowed the participants to talk freely about their opinions regarding the volunteer program, without feeling the pressure to talk about positive aspects of the program because their boss knew who the interviewee was.

In summary this study explored volunteerism among 10 older adults in a community hospital network in Southern Ontario. I believe that, by conducting this qualitative study, I was able to engage in a collaborative knowledge making process with older volunteers on volunteering in this community hospital network. By using a case study approach with in-depth interviews as my main method of data collection, I was able to gather thick, rich descriptive information from my participants. The following chapter will state my main findings with supporting evidence.

Chapter 4: Findings

This chapter will explore the key findings from the data collected from interviews with 10 older volunteer participants. I found four key overarching themes related to older adults' volunteering experiences in the hospital. These were: management's influence, reasons to volunteer, connections with others, and negative experiences of volunteering. In addition, two unexpected contextual factors -- the Auxiliary Factor and the Change Factor -- were found to have an influence on all of these four themes. The findings from the management's influence, reasons to volunteer, and the negative experiences of volunteering themes all speak to the first research question posed for this study namely: what are the experiences of older adults' volunteering in the community hospital network. The connections with others theme-related findings also contribute to the first research question, however it focuses more on responding to the second research question: does volunteering help develop social capital for adults and if it does, how. The findings from the in-depth interviews with older volunteers are supplemented with the findings from the analysis of the documents downloaded from the community hospital network's website, and the information obtained from the key informant interview.

Case Description

The case for this research project consists of the 10 older volunteers in a community hospital network in Southern Ontario. Please see Table 2 below for a summary of each hospital site where participants were recruited.

Table 2

Community Hospital Network Sites

Hospital Site	Total Number of All Volunteers	Status of Hospital Site	Number of Beds
A	145	-Full services on site -Regional cataract program	216 (115 are LTC beds)
B	44	-Very few services -Classed as urgent care	45
C	150	-Fully functional -Regional Acute Stroke Unit	144
D	73	-Urgent and complex care available	46
E	407	-New hospital site -Full service hospital	330
F	50	-Closed as of March 2015 -Was a continuing care complex	22

Note. I created this table using data obtained from the community hospital network's website, participant interviews, and the key informant interview.

Overview of volunteers. There are approximately 850 individuals who volunteer in this hospital network. The majority of volunteers are older individuals, with 75% of them being retirees. Approximately 80% to 85% of volunteers are women. In addition, there are only 150 to 200 student volunteers.

While I obtained my participants' demographic information such as age, employment status, marital status, and living arrangement, I found that these factors did not make a notable influence on their volunteer experiences. Thus I excluded most of

these demographic characteristics from my findings except for age and marital status. I felt it was important to highlight the benefits of developing connections for individuals who were not living with their partners. However even in this situation, individuals who lived with their partners, and individuals who lived alone both reported that they received strong benefits from developing connections with other individuals through their volunteering. This finding is then inconclusive and needs to be examined in future studies.

There are two groups of volunteers in the hospital network. The first group works in patient-oriented roles with staff such as nurses. The second group is an independent volunteer organization within the hospital known as the Auxiliary. For a brief description of all non-Auxiliary roles please refer to Table 5, and to Table 6 for all Auxiliary roles with the exception of fundraising.

The number of older volunteers, and volunteers in general, have been declining over the years in this community hospital network. Nevertheless, there is an ongoing demand for volunteers. Specifically, the hospitals in this network need volunteers who are willing to commit for a long period of time and are fine with volunteer roles that may seem menial to others. There is also a high demand for Auxiliary volunteers. This is a result of both a decline in the number of older adults joining hospital volunteering, as well as an increasing number of current older volunteers who need to leave volunteering for age-related reasons.

Change Factor. In recent years, this community hospital network has been undergoing drastic system-wide reorganizations. The hospitals in the network used to run separately, but 15 years ago they all amalgamated. Due to this amalgamation, various services have been reorganized and placed into one hospital in site E (See Table 3 below).

In addition, due to technological advances in recent years, hospitals have become more computerized. Table 3 below shows a list of the changes in the hospital network mentioned by participants:

Table 3

Changes in the Network's Hospital Sites

Hospital Site	Hospital Status	Changes in the Hospital
A	Downsizing	<ul style="list-style-type: none"> -Palliative care functionality has decreased -Change from Auxiliary-owned coffee shop to hospital-owned coffee kiosk
B	Downsizing	<ul style="list-style-type: none"> -Cafeteria closed -Hospital has become more of a “holding place” for patients -Patients coming in from all over the region now rather than just the local community -Doctors do not come to hospital as frequently as before -Babies aren't delivered in this hospital anymore -Number of patients in the hospital has decreased
C	Downsizing	<ul style="list-style-type: none"> -Volunteer roles/positions have been reduced in general -Hospital has become more “quiet” -No more magazine delivery to the rooms by volunteers due to new regulations
D	Downsizing	<ul style="list-style-type: none"> -Hospital has become urgent care rather than full service -Volunteers can only interact with patients at the Tuck shop -Do not work with nurses as often anymore -Less volunteer jobs available -Change in regulations on bake sales in the hospitals
E	Newly Opened	<ul style="list-style-type: none"> -A new hospital opened in 2013 and replaced the old one in a new location. -“New hospital is so much nicer” with extended services and facilities

F	Closed	-Hospital has closed as of March 2015 -Auxiliary here may join the family healthcare network
----------	--------	---

Note. I combined some changes that were very similar in nature. The words in quotation marks indicate in-vivo phrases.

These changes and the resulting hospital conditions thus affect various aspects of the participants' volunteer experiences. It is important to also note that these six hospitals can be divided into three different groups depending on the hospitals' conditions (See Figure 4 below).

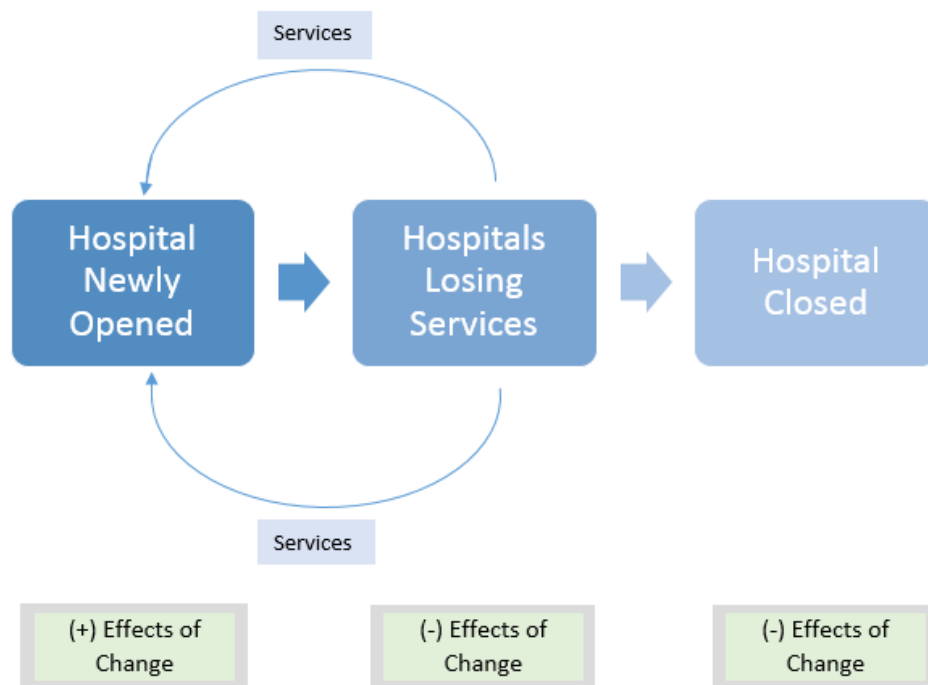


Figure 4. The three states of the hospitals in the community hospital network.

The first group comprises of the site E hospital, which is the newest and biggest hospital located in the largest city in the region, providing various kinds services to the surrounding communities. The second group consists of the hospitals that, according to

the participants, are downsizing and their services being amalgamated into hospital E. These hospitals are located in sites A, B, C, and D. Finally, the third group is comprised of hospital F, which was closing down at the time of the interviews, and is now closed.

Despite these different states among the six hospital sites, I present them as a single case (i.e. a community hospital network in Southern Ontario). This is due in part to the recommendations of the hospital network's co-researcher, and because of the overarching themes as well as factors that were found in all of the six hospital sites. As the influence of these changes were found in all four overarching themes, I designated these changes to be called the *Change Factor*, and discuss how it affects older volunteers throughout the Findings chapter.

Auxiliary Factor. Another important contextual factor, which has an effect across the overarching themes, is being part of the Auxiliary. The Auxiliaries are independent self-governed organizations of hospital volunteers, which have a long history. Auxiliary volunteers pay membership fees, and they have an executive committee with roles such as president and secretary. Auxiliary volunteers are called “Auxilians” and are generally female and older – “all in between 65 and 80” (Florence) – borrowing one participant's words. In the past, Auxilians were typically the wives of doctors or “prominent business people” (Florence) in the community. There are both honorary and active members. Honorary members are those who pay their membership fees and attend some events such as “an appreciation tea” (Florence), but do not take part in actual volunteering. Active members are Auxilians who volunteer in the hospital.

This hospital network has approximately 400 Auxiliary volunteers in total. When compared to the past, the number of Auxilians in the network has either decreased or

become stagnant due to the lack of interest of younger generations to join. This is partly because the Auxiliary volunteers are required to attend extra meetings and fundraising events in addition to their regular volunteer duties. Many new volunteers stated that they are not willing or able to give up time to take part in these extra activities.

There is one Auxiliary for each of the six hospitals as shown in Table 4 below. Auxilians have designated roles to play in the hospitals such as organizing fundraising events or managing amenities such as the gift/tuck shop in the hospital.

Table 4

Auxiliaries in the Community Hospital Network

Hospital Site	Formation of Auxiliary	Auxiliary Ownership or Helped Create	Number of Auxiliary Volunteers
A	Formed in 1945	Gift shop	40
B	Formed in late 1940's	Gift shop	22
C	From early 1900s's	Gift shop	42
D	83 years old	Tuck shop	115
E	Formed in 1865	Gift shop	144
F	Formed in 1920	Family care room	40

Note. I created this table using data obtained from the hospital network's website, participant interviews, and the key informant interview.

In this hospital network, one of the main roles of the Auxiliary is to fundraise for the hospital. Fundraising provides hospitals with the means to purchase new equipment and build new hospital units. The hospital's Auxilians take part in fundraising through the gift shop/tuck shop they "own", donating proceeds from the sales to the hospital. They also organize and host fundraiser events such as a "peach social" and "wrapping Christmas presents" for the surrounding community (see Table 7 for a full list of the

different fundraising activities stated by participants).

Thanks to their long history and independent status with some self-governance capacity, I found that being an Auxilian provides some unique status and privilege for older volunteers in the hospitals. Compared to non-Auxiliary volunteers, Auxilians have more freedom to use their own judgment and creativity to decide the contents of the services in their gift shops and fundraising events. For example, they sometimes change the menu in response to the customers' request, or they create new volunteer roles. Eight out of ten participants in this study happened to be Auxilians. They were expressive about the important roles that volunteers play in the hospital. They also shared some of their concerns of ongoing changes affecting "their" hospitals. I found that being an Auxilian has a positive effect on various aspects of volunteering experiences of older participants, especially on developing connections with others. Therefore, I named all of these Auxiliary-related features the *Auxiliary Factor*, which will be discussed in relation to the following overarching themes below.

Four Overarching Themes

The following section will describe each of the four overarching themes, along with their key sub-themes. These four themes include: Management's Influence, Reasons to Volunteer, Connections with Others, and Negative Experiences of Volunteering. In addition, participants' direct voices will be presented to provide support for my interpretations.

Overarching theme 1: Management's influence. I found volunteer management to play an important role in the experiences of older hospital volunteers, acting as both a gateway and motivator to continue volunteering. There are three major sub-themes to

management's influence: (a) recruitment; (b) training; (c) retention and turnover. Within this theme the participants talked more about recruitment strategies and related challenges, along with factors that influence the retention and turnover of older volunteers.

Recruitment. Volunteer recruitment was the gateway and first experience as a potential volunteer that older adults needed to pass in order to become full-fledged hospital volunteers. The procedures used in volunteer recruitment were standard for all individuals. Although participants were not too familiar with the recruitment process, they were able to recall some procedures they had went through including “filling out an application form”, “tuberculosis test (TB test)”, and “an interview with the volunteer coordinator”. These procedures were the same for all volunteers, regardless of age, location, or Auxiliary or non-Auxiliary volunteer status. Based on the participants, the demographic of volunteers in the six hospitals are mostly either “older” (over 50 years of age) or students. “Yeah, I work with a lot of older volunteers, because that’s what we have (slight laughter)” (Wendy). A few participants also noted that recruitment strategies could be geared towards students, but not towards older individuals.

I found that as there was a strong need for volunteers of all ages in the hospital, recruiting volunteers was a concern to many participants:

I think there's always an issue with not having enough volunteers in all programs these days. Because financially and statistically, health systems are depending largely on volunteers, the time and the services that they offer to assist trained personnel. (Amanda)

As this comment suggests, many participants viewed volunteers as an integral and essential part for the daily functioning of the hospital. A few other participants also stated

that having more volunteers in their own respective positions would be beneficial.

There were several challenges related to volunteer recruitment. According to the participants, with the exception of one hospital, most hospitals in the hospital network are facing challenges in recruitment: “In this area, you’ll find that our hospitals are having problems getting volunteer[s]...” (Sheila). Despite a strong need for volunteers, the hospitals have experienced difficulties in recruiting new volunteers. Participants suggested that these challenges might be related to required procedures, and recruitment methods. Five participants found that required procedures were a hindrance, in particular, the process of getting the TB test completed. When asked about how older volunteer participants may recruit other individuals, four participants named “word-of-mouth” as an effective strategy. In fact, some participants became hospital volunteers as a result of this informal strategy, and some had used it to recruit additional people. No one mentioned the online application method. This raises the question about the effectiveness of the network’s formal online recruitment method for older adults.

There were some suggestions to improve the hospital network’s volunteer recruitment. Many participants mentioned that volunteers have a preference for their roles: “If they didn’t want to do it, they wouldn’t take it” (Alice), or “I think everybody has their own little niche that they’re really comfortable with” (Meriam). These quotations suggest that it is important to match the volunteer position to the interests and the skills of the potential volunteer. A few participants also strongly stated that it was important for the hospitals to advertise more personal benefits, such as developing a “social connection” for becoming a volunteer, to community members.

Training. Once older adults have gone through the recruitment process, they need

to attend a general orientation and be trained on what to do in their volunteer roles. The orientation is held by volunteer management and is the same for all new volunteers. It consists of a tour of the hospital and an introduction of the rules and regulations in the hospital, such as proper hand washing techniques. Participants stated that trainings could also occur via self-training, or through an experienced volunteer (e.g. how to use the cash register at the gift shop). In addition, all volunteers have the opportunity to take part in optional ongoing education seminars held by the volunteer coordinator. These seminars discuss topics such as what to do if a patient falls and mental health issues.

Retention and turnover. Volunteer retention contributes to whether older adults want to continue their volunteer experience in the hospital. Within this sub-theme, participants talked more on whether retention is an issue; reasons for turnover, and importance of recognition.

Older volunteers usually had long retention periods in the hospitals. The hospital network has different retention periods for different groups of volunteers. There is a large group (approximately 200 people including students) who are likely to commit for only one year before leaving. The older volunteers, on the other hand, usually commit for as long as they can once they become a volunteer. As such, the majority of participants saw that volunteer retention as not an issue for older volunteers, except in regards to health. Health seems to be the only factor that would affect the ability of an individual to keep volunteering at the hospital: “Basically, the only reason people leave is if they get sick or, go into a nursing home, or retirement home (slight laughing)” (Sheila). Moreover, it is not necessarily their own health, but that of their significant others. Therefore, the second most stated reason mentioned by some participants was having other commitments,

namely “caregiving for family members” such as their husbands or grandchildren, which took away from the time for volunteering. Participants who mentioned these reasons usually talked from their personal experiences, where these factors caused them to decrease the amount of volunteering that they did in the hospital. A few participants also noted several other factors that might cause volunteers to stop or slow down their level of volunteering. These included weather, transportation, closure of the Auxiliary, and a lack of interest.

In addition to individual-level factors that increase volunteers’ turnover, the organization itself can contribute to increasing volunteer retention. Volunteer recognition is one of the strategies used by all the hospitals to increase retention. According to the participants’ stories, the hospitals showed their recognition in several forms. Participants stated that volunteer appreciation lunches or dinners were the “rewards” (Wendy) of volunteering: “You have to do something to recognize volunteers, I think” (Wendy). Some of the participants who were Auxiliary volunteers noted that the Auxiliary organized an additional appreciation luncheon just for their volunteers. Thus the Auxiliary Factor has a positive effect on the recognition of volunteers and the motivation of older adults to continue volunteering. Participants also appreciated ongoing education opportunities for current volunteers. In addition to these special forms of appreciation, some participants mentioned the importance of regular recognition. Participants stated how they felt appreciated by the hospital for their volunteer work: “Well, they ... you’re always told, you know, you’re always thanked for what you do” (Elizabeth). It appears that volunteer management of this hospital network utilizes several methods to recognize and appreciate volunteers, which may be another reason why older volunteers in this

study did not see retention as an issue. One participant, however, mentioned that hospitals could acknowledge volunteers' contributions even more:

The obligation part for the hospital is, for the [Hospital Network Name], to say to the public, we need you. We need you. You're important to us. Not just your money to build a new one [facility]. But we need you to be there. (Lianna)

From the participant's perspective, not only organizational but public recognition is key for the retention for current volunteers as well as for future volunteers.

In summary, the different aspects of the management's influence such as the recruitment of older adults into the hospital, the training of these volunteers, and methods for volunteer retention, all contributed to the older volunteers' experiences in this hospital network. The recruitment strategy that involves the volunteers themselves seemed to work best to recruit other older adults. Once they started volunteering, these older individuals continued to work long-term, unless their health or their obligation for family members slowed them down. Given the increasing demand for recruiting more long-term volunteers in the hospitals, these findings are useful to volunteer management.

Overarching theme 2: Reasons to volunteer. Volunteers' motivations are the reason that older adults will start, and continue having their volunteer experience in the hospital. This theme consists of two sub-themes: (a) to start volunteering; (b) to continue volunteering.

To start volunteering. Though there are both internal and external reasons to start volunteering, I found that many participants' reasons were internal. Most participants stated, for example: "If you're gonna volunteer, you have to want to" (Alice), and "um, with me, it was something that I've always said I would do once I retired -- I would

volunteer” (Sheila). This “want” to volunteer was present in most of the participants’ responses. However, there seemed to be more than one type of “want”. These include, the want to volunteer in a healthcare setting, the want to help others, and the want to feel useful. Some participants noted that they wanted to volunteer specifically in a healthcare setting: “I wanted to work in the hospital. So I always said I was going to, and I did” (Sheila). When looking more in-depth as to why they wanted to volunteer in a healthcare setting, one participant stated her familiarity with the hospital environment due to her previous employment, while a few noted their interest with the healthcare or nursing field: “Um... I wouldn’t say that I ever wanted to be a nurse, but I was always interested in caring for the children when they were sick...” (Lianna). Another participant suggested her want to care for others as an entire community: “I want to take care of this community, our little community here” (Meriam). This quotation relates to another type of want that was mentioned by a few participants, namely, “want to help others”. As these examples show, motivations to volunteer at hospitals arise from several different reasons.

Although the majority of participants referred to themselves when they talked about internal motivations, they tended to refer to other individuals or hypothetical situations when talking about external motivations. Four of the participants talked about “being pressured” to volunteer, while three felt there was no such situation where individuals would be pressured to volunteer. One participant described a situation when she was asked to take part in volunteering: “what I did ... I just agreed to (laughing)” (Meriam). Once started, it did not take long for her to become very fond of her volunteer position, which may indicate that she was not actually “pressured” to volunteer.

To continue volunteering. It was clear that the reason to continue played a large role in whether older volunteers stayed volunteering for a long period of time. There were several reasons to continue volunteering such as affection towards the volunteers' hospital, commitment to volunteering, a want to do more tasks and jobs, and psychological and physical benefits. Several participants stated strongly that it was their affection for "their" hospital, that kept them volunteering: "This is my hospital. I don't care about what happens in the region, I don't care (slight laugh) what happens in any other town...I only care about my hospital" (Lianna). "Well, they know how near and dear this hospital is to my heart so..." (Wendy). It seems that being able to contribute to "their" hospital, and not just any hospital, makes a difference as to why older volunteers want to continue volunteering. One participant even stated that: "I told them [probably volunteer management] 'if you move to [City Name], I'm out of here'" (Alice). This comment suggests that if "their" hospitals were closed due to the ongoing changes in this hospital network, some participants would be unwilling to continue volunteering in other hospitals.

One participant, as seen in the following quotation, also talked about her commitment to volunteering at the hospital, regardless of the hospital's status in the network:

We do what we can, and we keep doing (slight laugh) what we do. And if they ever close us (slight laugh), that'll be it (slight laugh). But-but we'll keep trying, you know, we'll keep doing, and then a little bit that we get.....So as long we can keep it going, we'll keep it doing so (slight laughter). (Florence)

The other participant mentioned that her continued commitment stemmed from her strong belief in volunteering in her own community: "And uh, that's how much volunteering

means to me. It's just to be able to be there for other people. And uh, maybe someday if I need them, they'll be there for me too, hopefully" (Clarissa). As these quotations indicates, these current older hospital volunteers are very affectionate towards their own hospitals and communities, and adamant on their resolve to keep volunteering as long as they can, while facing some challenges due to the changes occurring in their hospitals (e.g., closer of certain facilities). It was apparent that many participants were aware and seriously concerned about the consequences of ongoing changes in the hospital network to their communities.

In conclusion, I found that the "want" to initially volunteer was internal, and the "want" to continue volunteering was based on the affection and commitment that volunteers had towards their own community. In addition, external pressure to volunteer did not seem to be a major issue for the participants. In summary, these "wants" were the reason why older volunteers started and continued having their volunteer experience in the hospital.

Overarching theme 3: Connections with others. Volunteering in this hospital network enhanced the development of connections by older adults. There are three types of connections developed by older volunteers: (a) relationships developed among older volunteers; (b) relationships developed with staff; (c) relationships developed with patients, families, and the community. The older volunteers created many connections through their volunteer position with varying degrees of closeness. There were both hindering and facilitating factors for all three types of relationships, some of which were overarching across all three types. In addition, many of these factors overlap with Auxiliary and Change Factors. Participants described that not only did older volunteers

benefit from the creation of these connections, but so did patients, families, the hospitals, and surrounding community.

Relationships developed among older volunteers. All of my participants experienced the development of relationships with other older volunteers through volunteering at the hospital. These included becoming an “acquaintance”, “close friendship” within the hospital, and “close friendship” beyond the hospitals. This section will only go over the relationships developed with other older volunteers, as just two of the participants briefly mentioned student volunteers.

Becoming an “acquaintance” refers to participants knowing of other older volunteers and creating small talk with each other, thus only developing weak ties. When looking at the meaning behind the second degree of closeness (i.e. “close friendship” within the hospital), participants described the relationship in which they were close enough to sit down, chat with, and call other volunteers once in a while. “Close friendships” beyond the hospital meant that participants saw other older volunteers outside of the hospitals. It is notable that participants tended to use the word “close” to describe their friendships regardless of them occurring within and/or beyond the hospitals.

I found that all of the participants created multiple relationships with other older volunteers in varying degrees of closeness. The following quotation provides an example:

I mean when we're all together, we all ... everybody's talking and happy and laughing and stuff like that. And we help each other when we had our peach social. Everybody's working together. But then there's a few that you pick that you become a little closer with. We're all friends. But you know there's a couple that you do more with than you do with the others, you know. I mean if they invited me I would go. The one lady that sells tickets I've been to her home, she's asked me to drive her to the doctor. So we've kind of got a little relationship there, you know? But it's, we don't really-she's quite involved with her children too, so we don't visit that like socially or anything, but I feel we're close friends, and so you

know there's another friend (laughing) yeah. (Florence)

This quotation provides an intricate picture of how one participant could develop multiple levels of relationships with her fellow older volunteers, which also provided her with both emotional and practical supports. In this way, most of the participants mentioned that they had created “friendly” bonding with other older volunteers. It was intriguing that, however, most participants seemed to place more value on the quality, rather than the quantity, of social network developed through their volunteering.

Facilitating factors. There are a number of factors that may facilitate the development of bonding relationships among older volunteer participants. This section will explore these factors, taking into account how some of them may be influenced by the Auxiliary Factor. According to the majority of participants, several factors facilitate the development of their bonding relationships. These include: getting along with everyone, “circles within circles”, Auxiliary events, hospital size, and the older adult’s volunteer position.

Being able to get along with everyone was strongly stated to be a crucial facilitating factor. For example, one participant stated that: “...like I said I’m easy to get along with and I don’t, I try not to complain about anything (slight laugh). Sometimes it’s not easy” (Clarissa). As this quotation implies, there are occasional conflicts between volunteers. However, older volunteers’ conscious efforts helped them to get along with more individuals. A few participants stated that they were part of “circles within circles”. Participants sometimes saw others not only through their hospital volunteering, but through other common activities that they do such as volunteering in a hospice, and helping older adults with Alzheimer’s. This then provides them with other similar topics

to converse about, which in turn seems to let them make their relationship stronger.

“Circles within circles” was the factor that was found more often in larger sized hospitals.

Becoming more involved in Auxiliary meetings and events acts as a strong facilitating factor for half of the participants. One participant stated that by being part of the Auxiliary executive team, she was more involved with getting in touch with other Auxiliary members. For example, Florence described how she met most of her fellow Auxiliary volunteers:

[...] I met them all [other Auxiliary volunteers] just through the Auxiliary [...] you know you go and then, if you become on the executive you get a little bit more involved because there's something going [on] so you're involved and they come and then you have to call these people to come to the meetings so you get to know them then. (Florence)

As Florence was on the executive team for the Auxiliary, she was able to interact more with the other Auxiliary volunteers who came to the meeting as well as contact them outside of these meetings. A few other participants also supported the finding that Auxiliary events helped older volunteers meet with each other: “...the end of March and that's where all the volunteers gather for a convention--you meet a lot of people other people from other Auxiliaries of Ontario” (Clarissa). As these quotations indicate, active involvement in the Auxiliary acts a facilitator to developing relationships with other older volunteers through various social events.

The “volunteer's position” seemed to also matter in two important ways. First, the longer they stayed in the same position, the better they developed closer relationships: “I think, there was more bonding the longer you're with them...” (Wendy). This suggests that the hospitals can promote the development of more connections among older volunteers by having them stay longer in the same volunteer positions. Second, some

participants mentioned that the volunteer position determines whether you can meet others or not: "...now if there was only one person [in your position], you wouldn't have the opportunity to develop any relationships. But we have two people, all the time and in that way they do develop relationships..." (Wendy). Wendy went on to say that the gift shop, where she volunteers, has the regulation that two volunteers must always work together. Since this gift shop is run by the Auxiliary and the Auxiliary can create these rules, one can see another positive influence of the Auxiliary in this case.

Hindering factors. I found that there are a few factors that hinder the development of relationships between older volunteers. Several participants suggested the following factors: personal factors, volunteer's position, and changing conditions in the hospital.

In regards to the personal factors, two participants raised a point that other commitments were a reason as to why some relationships did not grow into very close friendships beyond the hospital setting. For example, one participant stated that she has already committed to multiple volunteer positions outside of the hospital. In addition, one of the participants also stated that: "...when you get older you don't want to go out at night..." (Wendy). These comments suggest that not only other commitments, but also age-related physical barriers may stop the progression of a stronger relationship from forming.

Half of the participants adamantly stated that their "volunteer position", which was mentioned as a facilitating factor, worked as a hindering factor as well. Their position determined the regular work schedule, location of their work, and consequently the chances to meet new volunteers besides their regular company. In fact, one participant worked in a single-person position, thus she did not have the opportunity to

work with other volunteers. The other participant said: "...because, we have a schedule for the gift shop for working, I would only see some other people maybe at the annual general meeting" (Sheila). In addition to the schedules, a few participants mentioned the physical condition -- being located in a corner of the hospital -- made it difficult for participants to interact with other older volunteers who did not come by that area of the hospital.

The current conditions in the hospital site, which resulted from the ongoing changes in this hospital network, seemed to have a direct connection with some of the hindering factors experienced by older volunteer participants. For example, one participant mentioned that downsizing in the hospital affected the available jobs and roles for volunteers in the hospital: "Back earlier, there was a quite few things to do. But, not anymore, our hospital is very uh, I would say, quite quiet now, compared to what it used to be" (Alice). As the hospital became less busy due to changes in the hospital's structure and purpose, volunteers were left with less roles to fulfill. This also led to reduced chances for older volunteers to meet other new volunteers. In relation to the current conditions of volunteers, a few participants mentioned that if the hospital was able to host events for the volunteers, this would give them an opportunity to interact more with other older volunteers. Furthermore, it is noteworthy that, as one can see from the descriptions above, that some factors such as the "volunteer position" were considered by participants to be both facilitating and hindering. The effects of these factors also differ depending on the conditions of the hospital site itself.

Bonding benefits. All of my older volunteer participants received certain benefits from developing relationships with other older volunteers. Generally these include

various psychological and social benefits. In regards to psychological benefits, participants experienced them in a few different ways. For example, half of the participants stated that they felt less alone:

I work with some really nice people and, they're all very caring. When my husband died they were, you know really, really caring (emotional voice) -- And they are...they're really like a family almost now. (Wendy)

This quotation displays how the participant appreciates the “family” like relationships with other volunteers, which in turn helped to reduce her loneliness after the loss of a loved one. Wendy’s comment also suggests that volunteers who have experienced a personal loss of relationships (e.g. becoming widowed) may benefit even more from developing new relationships through volunteering. Other participants appreciated that the act of socializing with others in itself met older volunteers’ needs.

Furthermore, there were practical sides of social support benefits that participants received from the relationships where they were able to rely on each other. Some of the examples provided by several participants included driving others to events and covering each other’s shifts:

You really feel you can call on them if you had a problem. You become friends. If you have a situation, you can call in sick, and you need help with this, and you sort of volunteer there with them. It’s wonderful. (Meriam)

As Meriam suggested, the network of people who they can rely on provides not only emotional support for them, but also instrumental and practical support.

Relationships developed with staff. The older volunteers created relationships with varying degrees of closeness with staff. Unlike the close friendships among older

volunteers, which sometimes go beyond the hospitals, the relationships with staff only occurred in the participants' respective hospital locations. This could imply that compared to the bonding among older volunteers, relationships with staff are more formal in nature, perhaps reflecting some power dynamics between the volunteers and the staff. These relationships can be divided into two major groups: acquaintances, and some degree of "friendship". Contrary to the relationships developed between older volunteers in the previous section, participants did not describe their relationships with the staff as "close" friendships, adding to the assumption that these relationships may be more formal in nature.

Seven out of the ten participants briefly stated that they had become acquaintances with staff. The quotation below indicates how a participant developed friendly yet rather distant relationships with staff:

They're very friendly. They'd meet you somewhere and you know [them]. But no, not to say, like go out together. No, no, not, I have none of them....I know, I'm sure, no I know I've never been in real close contact with any of them, no. (Alice)

As this quotation implies, this participant acknowledged that she got along with staff.

However, she considered it to be simply collegial.

Those who developed some friendships with staff described their relationship as follows:

Yeah, we're friends with the nurses come in, and have a maybe a lunch sandwich or something, and you get to know them. People from the clinic, the doctor's clinic next to the hospital we have, and getting to know all of them pretty well in there so. Not personal friends to go out and have dinners with and that, but yeah, they come in, and they talk away to you and joke with you and stuff... (Clarissa)

A few other volunteers also stated that: "...the staff we get on tremendously well with everyone. We sort of joke around, but I can't say, I see them as not someone I'd have a friendship with out of the hospital" (Sheila). As this quotation suggests, although participants do not see staff as people who they can become "personal friends" with, their connections with hospital staff are friendly enough to call them "friends".

Facilitating factors. I found that there are factors that facilitate relations between older volunteers and staff in the hospital. These factors were discussed by several of the participants. Similar to the relationships among older volunteers, all of these participants overwhelmingly stated that the "volunteer position" was the most influential facilitating factor. For example, a participant that worked in the operating room stated that: "I interact a lot with them [nurses] when I'm on the floor" (Elizabeth) and "I think when I was president [of the Auxiliary], I got to know the nursing staff really well" (Amanda). Some other positions that let older volunteers interact with staff include: emergency, ICU, and clinics. Please see Tables 5 and 6 for a full list of these locations. Thus the participants' positions are key to facilitating these relationships with staff.

Hindering factors. There were also factors which hindered the relationships between older volunteers and staff. The most notable hindering factors mentioned by almost all participants were the ongoing changes in the hospitals, such as staff changes, closures, and volunteer changes.

Several participants implied that changes affecting hospital staff impede volunteers from building relationships with these individuals. Some participants stated that there was a lack of doctors in their hospital as a result of the closures of some facilities, and in some cases changing from a full-service hospital to a "rehab" hospital:

We don't see any-we rarely have ever seen any doctors. We don't have any on staff. We-some of them have clinics. And they're usually in the afternoons, and if I'm there, I might see one or two might come in for a coffee. But you really don't see the doctors at all. Unless you go down to emergency to urgent care and you might see them then... (Sheila)

This comment indicates that the number of doctors in the hospital has been decreasing due to the downsizing. In relation to this point, participants also suggested that they would not be able to make closer friendships with staff outside of the hospital setting: "Cause a lot of them do not live in town" (Meriam). One participant shared how transferring some services to larger hospitals had changed her hospital:

Because there's, these people are coming in from [out of town] their doctors aren't gonna drive to [hospital site in local town] you know [...] but at one time like every doctor came in, every morning and visited the patients the hospital was buzzing, it was active... (Florence)

This quotation displays the difference in the hospital's atmosphere between the past and the present. As this example suggests, transferring services to larger hospitals may have led to doctors and staff also moving to these larger hospital sites or even to other cities where they can find jobs. This fact seemed to bother older volunteer participants who had been witnessing these ongoing changes. Participants also saw that this makes it difficult to create long-term close relationships with hospital staff in their own local community.

A few individuals pointed out "the closure of communal areas" in the hospitals as a hindering factor. In particular, one participant adamantly stated how the closure of the cafeteria affects the gift shop where she is working:

When the cafeteria was there, they [staff] would come down, they would come into the gift shop, they'd buy something. [...] And if they come down, maybe they'll have a break, they'll buy chips or pop or somethingbefore it was nice,

because they'd come down the cafeteria, you'd always see them coming off the elevator or you know they'd pop into the gift shop maybe pick up something but, it's quieter now... (Florence)

As Florence suggests, the closing of the cafeteria due to the downsizing indirectly but greatly affected her chances to interact with hospital staff. As these examples suggest, the Change Factor clearly had a major influence on the development of the link between older volunteer participants and staff.

Linking benefits for hospitals. There were benefits that hospitals received as a result of the linking relationships developed between older volunteers and staff. This was stated by half of the participants. The following quotation displays how the hospital benefits from the collegial and friendly connections between older volunteers and staff:

Well, I think it's good for the hospital. 'Cause people – well, even it reflects on you when customers come in. If you're happy, you know, and it reflects on the staff. If you're happy that you're there, and you're happy with the person that you're with, and you're not just stuck there, and you don't want to be there, uh I think the relationships help that too? Because if you are going into work going “ugh I gotta work, so today ugh”, like you wouldn't be the happy person that you should be? And I think it reflects back on the hospital, and then the public will say “oh is it ever nice to go into the gift shop, they're so friendly and so nice” and you know. Yeah I think it does I think it does. (Wendy)

As this quotation suggests, when older volunteers create “happy” relationships with hospital staff, it influences staff and patients alike by creating a “positive atmosphere within the hospital” (Amanda).

Relationships developed with patients, families, and the community. The third type of connection echoed across the stories of older volunteers consisted of the relationships with people who come to the hospitals from surrounding neighbourhoods. The majority of participants talked considerably about the positive relationships they had

developed with patients and families. Participants described three types of relationships between patients and families: small talk, some friendship developed, and close friendship. Small talk refers to participants saying phrases such as “hello, how are you” (Sheila), or talking to patients and families while they are waiting for an operation:

And then the patients-when I go back to talk to them [patients] I always ask them “How are you, are you ok? Do you need anything? Are you warm enough?” And things like that you know...just general everyday things. (Elizabeth)

As these quotations suggest, although older volunteers’ chats with patients seem to be nothing more than friendly greetings, these small talk may help to relax patients and families. The second degree of closeness is when participants create some degree of friendship-like relationship with patients or families. However these friendships stay within the volunteer location with limited interaction:

Some [patients] have to come every 3 months; some have to come every 6 months. Well, then they get to know you, and you know, get a little bit friendlier. But, most times it’s just [communicate with them] for half hour? (slight laughing), yeah... but no, you don’t make contact with these people after that, or nothing else, no. (Alice)

As one can see from this example, some older volunteers created some degree of friendships with patients and family members who visit hospitals regularly. The third type of relationship has the strongest link. These ties occur inside the hospital location where participants interact with patients or families over time. One participant shared an episode of her long-term friendships with a young man and his family in this way:

A young man was coming in there [a hospital site] because he was trying to break the bad habit that he picked up, with drugs. And, you know he’d talk to us one day and I said to him ... well this was before his first baby was born ...and him and this girl, they had a child together. I said to him, “you know, this is good that

you're coming in and getting help. You have a child on the way".... And he came in one day, and I said, "how are you doing?" And he said "oh, I'm not doing too good. Uh, my wife is hungry at home", he said "I have no money to buy anything, we have no money" so the girl [another older volunteer] I was working with at the time, we bought a sandwich for his wife, and one for him, and gave him. [...] He says "but I don't have any money to pay for that." I said, "me, and my friend here, we're buying it, we're paying for it for you, you take it home and you enjoy it." [...]. But anyway ... I guess he was on...some kind of assistance with the government or welfare, and he'd come in there one day, and he wanted us to take money for, and I said "no, we're not taking your money, you keep that, you're gonna need it." (Clarissa).

This relationship continued even after his baby was born:

And finally his wife had the baby and (slight laugh), he was so proud of this baby he was going around showing it to us all, and he's still, he's still coming in there. He's not coming in as often as he used to, so he must be getting a lot better than he was. But he was a nice fellow, you know? And we-I felt sorry for him, so that's another part of volunteering to somebody, that's, down and out. And, he still comes in, and he's still friends with us. He's just-well he must be friends with the other girls too. But particularly with the girl I work with and myself, he was always so thankful that day when they didn't have no money to go and buy food. (Clarissa)

This episode gives a clear example of how older volunteer participants can develop long-term friendship-level connections with some patients and their families. One could see older volunteer participants' strong empathy and kindness as well as a sense of satisfaction or pride in Clarissa's story.

However, these close friendships with patients do not always have happy endings, as Meriam described as follows:

I used to get quite close with (emotional voice). I had to actually pull back some. I got quite close to a couple of people, and I did go to their funeral. I was very attached to them. But I did NOT know before the hospital, that they had been there several months and I had watched them deteriorate. It's sad. It's sad you know, you become very attached to some people. (Meriam)

This quotation implies how older volunteers can develop strong ties with some patients in the unique setting such as the hospital, and how they can invest their emotions to these people. This is also an example to show the long-term commitment of older volunteers that was commonly found at all six hospital sites.

A few participants went beyond talking about the relationships between patients and families, and talked about how they developed relationships with members in the surrounding community through local fundraising events. Among the few participants, there was one participant in particular who spoke energetically about these relationships:

I did three fashion shows. Fifty people at each sitting, and I raised about \$2,000. And that was for different things ... like we bought wheelchairs or whatever ... it's all to buy equipment for patients, that's what I was involved in. And then Riley's [community member] wonderful. She did my food for me, and then I got to be a lot. Lina [business owner] who did the buttery, she owned the buttery in town, which is no longer here, she donated all sandwiches to me for it, and the gatehouse donated the hors d'oeuvres for me, and Reif [business] donated the wine. So, yes the whole community got involved and just did that they're very supportive, of our hospital here, because they know what it does. (Meriam)

This quotation demonstrates how Meriam developed solid relationships with multiple community partners through her Auxiliary fundraising work. However, this type of relationship with community members could be a unique case because of her Auxiliary position.

Facilitating factors. Similar to the relationships in the previous sections, I found that most participants felt they owed their “volunteer position” and “location” in the hospitals, in helping them develop these networks with patients and their families. Participants stated that volunteer positions, which require frequent interactions with patients, was a facilitating factor to developing relationships with them. For example: “I think they're, the people that volunteered for palliative care, would develop more

relationship with the family, and because, they're more often in that" (Wendy). Some other examples of patient-oriented positions or locations stated by participants included: the clinic, operating room, emergency, information/front desk, and Auxiliary programs such as Friendly Visiting. Two of the non-Auxiliary volunteers worked in the clinic and operating room positions, while one of the Auxiliary volunteers was part of Friendly Visiting. For a more detailed list of volunteer positions and locations for all volunteers not just the participants in this study, please see Tables 5, 6 and 7 in the Appendices. One participant noted that in addition to having a volunteer position, having fundraising events through the Auxiliary might have allowed them to develop relationships with patients, families and the community.

Hindering factors. There are also factors that get in the way of developing relationships between older volunteers and patients and families. These included: the volunteer position, reduced length of patients' stay, and new rules and regulations. All of these factors were also related to the Change Factor.

Some participants noted that they do not see patients or families frequently due to the fact that their "volunteer positions" are not patient-oriented, or their schedules are tight. Additionally, one participant did not create these relationships because she had a volunteer position in an isolated location where she did not have opportunities to converse with people. Similar to the case of bonding between older volunteers, having an isolated position affects participants' relationships development with patients and families. A few participants pointed out that the Change Factor – cut-backs to their hospitals – had resulted in less patient-oriented roles.

In relation to the hospital's current condition, one participant mentioned the

“shorter length of stay” as another hindering factor. She said that the change from being a full-service hospital to more of a “rehab” hospital made it harder for patients to stay in the hospital for as long as they used to be.

In the same vein, there was one participant who talked about how change in the hospital resulted in new “rules and regulations”, which in turn hindered her from creating closer relationships with patients and families. She gave the example of the Auxiliary members being allowed in the past to go room to room with magazines for the patients. This role allowed her to develop stronger relationships with the patients. However, as a result new rules and regulations in regards to cleanliness, in particular, the cleanliness of delivering magazines room to room, this participant barely gets any interaction with patients currently: “I miss being with the patients (exclamation)” (Lianna). The participant’s relationships with these individuals have become weaker over time, which was seen by this participant as a negative consequence of the Change Factor.

Benefits for older volunteers. I found that there were benefits for half of the older volunteers in my study through creating relationships with patients, families and the surrounding community. A few of the participants said that they enjoyed contact with people in general, while some participants specifically stated that they enjoyed and appreciated getting to know community members and patients:

Yeah I think I got to know the people-the local people a little bit better. Um, well I was...more part of the community -- you’re not only sort of working with people at the hospital, you’re working with people you get to know within the community. (Amanda)

This quotation indicates that working with community members through her volunteer position was seen as beneficial to this participant, by strengthening her sense of

belonging to the community. One participant also talked about how the Auxiliary's fundraising acts as a topic of interest for community members:

When we present our moneys, it's always in the paper. So whenever you go into the mall, "Oh I saw your picture in the paper and it's wonderful, what you're doing for the hospital" you get, that feedback from, from the uh community. Um, they see what the volunteers are doing and they do-do comment on it. (Wendy)

Wendy's account suggests that the acknowledgement and recognition from community members for their Auxiliary work are a great source of well-being for her. It seems that taking part in Auxiliary fundraising events is beneficial for both the community as well as older volunteers.

Benefits for patients and families. There were benefits for the patients and families from the relationships that they create with older volunteers. These participants stated that families and patients "love it here" (Meriam) and that some patients for example: "thinks it's almost like family when she's at the hospital" (Sheila). One participant vividly described the type of comforting benefits that older volunteers may be able to provide patients and families through their relationships:

And, I mean there's times when I see, people coming in there [the hospital], and you know... their loved ones are near the end. And you try to be, positive with them and, talk to them. I don't run out in the hallways and catch them. But if they come into the Tuck Shop, and I'm not saying I go to them being nosy and ask questions because, I just ask them if they are ok, and uh, there's lots of times they break down, and I'll just try to comfort them. And that's the only thing you can do, because, (sigh) it's hard to comfort somebody when they're hurting like that, you know? And, but you do your best you try not to ask questions. You don't ask questions of what they died from, or how it happened or anything. You're just there to, try to show some kindness towards them and, love you know? So that's about it. It's a difficult thing. You know when you see people in there, you know that they're not well. (Clarissa)

This quotation displays how family members may benefit from a relationship with older volunteers. It may be possible that patients and families receive benefits from just developing connections with older volunteers regardless of the degree of closeness of these relationships.

Benefits for the community. In addition to the previously mentioned Auxiliary's fundraising to hospitals which was acknowledged in the local newspaper, I found that only two other participants mentioned the direct benefits of the Auxiliary volunteers to the surrounding community. However, it is worth including their perspective as a unique case, since they both volunteered in the hospital that was closing. The strong relationships developed by the Auxiliary members helped them "stay together" even though their hospital was closing (at the time of the interview): "We have to close. We have to be attached to a HOSPITAL, to be an AUXILIARY, a hospital auxiliary. We can be an Auxiliary but we can't be [the] hospital's Auxiliary. So we're gonna be the [Hospital Name] healthcare network" (Meriam). Through the strong relationships among the Auxilians and their attachment to the community healthcare, Auxiliary volunteers in this closing hospital seemed to decide on their own to keep volunteering for their healthcare via a different avenue (e.g. family healthcare team): "...our auxiliary of course is changing their whole direction? Because our hospital is closing? They're becoming -- they will be becoming a lot more community oriented, and working for, or with, rather not for, with the community health team" (Amanda). Even though the closure of the hospital had a negative effect on the Auxiliary and surrounding community, the strong bonding that Auxiliary members have with each other in this community seemed to help mitigate the negative impact of the inevitable change. Although this is a unique case

caused by the drastic change such as the closure of their own community hospital, this episode shows how the surrounding communities may benefit from these devoted Auxilians who strongly committed to save the healthcare in their own communities.

It seems that the reason the Auxiliary is serious about helping their community is because of their awareness of the importance of having their “own hospital” in the community: “...the hospital was-meant a lot to the community” (Amanda). This also suggests a strong “sense of community” based on the connections that the Auxiliary had developed with the local hospital and its patients and families over the years. The two participants, who were Auxiliary at the closing hospital, stated that they lived in a small, retirement community composed mostly of older individuals who may need a good healthcare centre close by. One of the participants went on to say that having the hospital in the community was beneficial as they had: “...nursing chronic care beds, to be so close to people, their loved ones living in the community” (Amanda). Having their “own hospital” in their own communities allows not only older people, but also everyone in the community to easily access care for their loved ones. As such, a few participants raised their serious concerns about the consequences of the downsizing or closure of their local hospitals. This is an important issue to participants as there seems to be a lack of transportation from various small communities to the large hospital sites.

Conclusion of the connections with others theme. In conclusion, relating these findings back to the research questions, the key finding for this section was the fact that older adults being hospital volunteers, seemed to increase their development of connections with others. There were three main types of relationships created by older volunteers. These were: relationships with other older volunteers, relationships with staff,

and relationships with patients, families, and the surrounding community. Within each type of relationship, there were different degrees of closeness. Regardless of the closeness, most participants described these relationships as collegial, friendly, and caring social networks developed through their volunteering in each hospital site. One of the main findings that emerged from this section was that all these relationships were beneficial for all parties involved. When the older participants created these relationships, they not only benefited themselves, but they also benefitted the patients and their families, the hospitals and the surrounding communities as well. The other main finding is that contextual factors surrounding older volunteers in each hospital affect the development of these relationships as facilitating or hindering factors. The “volunteer position” factor however works either as a driver or an impediment in all three relationships types. When examining volunteer experiences of both Auxilians and non-Auxilians in the three different hospital conditions (i.e. expanded, sustaining, and closing), I found that the Auxiliary Factor was generally facilitating these relationships, and the Change Factor was generally hindering.

Overarching theme 4: Negative experiences of volunteering. The last overarching theme discusses some of the negative experiences of volunteering that some of my participants had as volunteers. Compared to the previous theme, this theme is much smaller. However, I decided to include this theme as it reveals some downsides that older hospital volunteers face from time to time, which can be seen as potential “negative consequences” of community volunteering. The sub-themes included leaving volunteering, difficulty of working with very old or student volunteers, becoming burnt out, and frustration about the management. Some participants stated that they knew other

older volunteers who had a bad experience, and as a result had left. One participant noted a complaint given by a patient about an older volunteer, whereas another noted “rudeness” by other older volunteers, both of which were reasons as to why older volunteers left. In addition to having these bad experiences, a few participants stated the difficulty to work with certain types of volunteers. For example, one participant alluded to the disadvantage of having “really old” individuals volunteer in the hospital, though she was unclear as to why. Another shared an incident regarding student volunteers who created a mess in the gift shop. The third type of negative aspect named by a few participants was becoming burnt out. For example: “But, she’s burnt out now. She’s just burnt out and she just, just wants to give it up” (Wendy). Moreover, one participant stated that she herself had slowed down in regards to fundraising because she was burnt out: “...and I’ve done a lot of fundraising I’m kinda burnt out right now I’ll help, I’ll HELP with fundraisers I just don’t want to run one right now” (Meriam). Lastly, one participant talked about how she felt there was a lack of acknowledgement in regards to her suggestions to improve the quality of patient and family visits:

Now can you tell me where I can get coffee? Because they don’t have a proper signage. ...Walk in the front door, there’s an information telephone, if you want to find out where a patient is and then up here, they have a black and white sign, paper, that points down towards the cafeteria. Well people aren’t looking. I have spoken to the planner, and several people have said ‘why don’t you get an easel, as people walk in the door, they can see the easel with a nice big bright sign on it, pointing to where they can get their coffee?’ They [the hospital administration staff] won’t listen. We have some-(slight laugh) somebody at the church that would do, a big sign ‘cause she’s a graphic artist, and she did do some signs for us. But they just won’t-they won’t listen...Really. This discourages me ... (Wendy)

This quotation suggests Wendy’s frustration that the hospital was not taking their suggestion into consideration. However, she goes on to state that: “...I don’t cut off my

nose despite my face (slight laughter), you know [with] things like that. I would not quit just because, they won't listen to me" (Wendy). Even though Wendy may see this disregard of her suggestions as a negative experience, she does not let it affect her ability or commitment to volunteer at the hospital. This is also an example to show that the positives of volunteering, such as the benefits received through developing connections with others, outweigh the negative experiences encountered through volunteering. More specifically, this suggests that even though negative experiences are unavoidable in community volunteering, they may be buffered by more positive experiences of volunteering.

Summary of Findings

In summary, the themes of reasons to volunteer, management's influence, and negative experiences of volunteering relate to the first research question on what older volunteers' experiences are in the hospital network in Southern Ontario. The connections with others theme on the other hand speaks more to the second research question on if and how volunteering helps develop social capital for older adults. Based on the overarching themes, the factors influencing older adult volunteers in this hospital network, and the research questions for this study, I developed a visual diagram (see Figure 5 below) to describe the relationships between the four themes (i.e. older adults' reasons to volunteer, management's influence, connections with others, and negative experiences of volunteering) and the two contextual factors (i.e. Auxiliary Factor and Change Factor) in this case (i.e. the hospital network located in Southern Ontario):

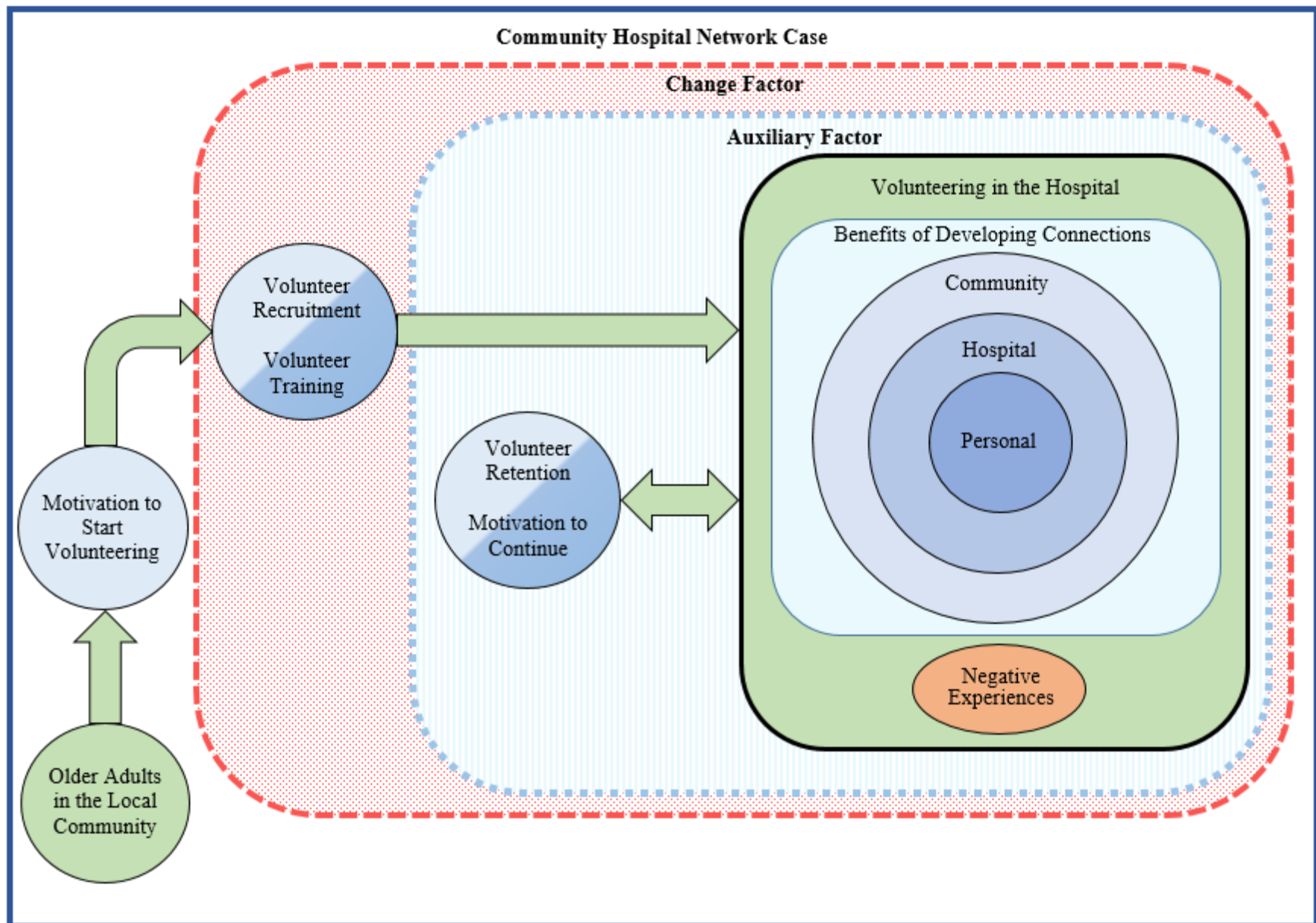


Figure 5. The experiences of older adults as volunteers in the community hospital network. Size represents importance of the findings, however the equal split between colours is not representative of any findings.

The four themes are coloured in shades of blue or orange, and the two contextual factors are represented by dotted lines with patterned shading. The green arrows represent the older adult volunteers. A proportion of individuals in this Southern Ontario region consist of older adults (see bottom left circle on the diagram). Among this group, there is a group of individuals who are motivated by internal reasons (e.g. want to help others, use of their previous experience and skillsets), to start volunteering in the hospital. Those who decide to volunteer at the hospital need to go through the recruitment and training process influenced by the volunteer management in this hospital network (i.e. screening process including a tuberculosis test and an interview with the volunteer coordinator, after which there is a general hospital orientation and training). When they complete this process, these older adults finally become volunteers at the hospital (represented by the shaded green rectangle).

Older adults can receive benefits from developing connections with others while volunteering at the hospital. These benefits can be divided into three levels: “personal” benefits for the older adults such as general well-being, “hospital” benefits such as creating a friendly and caring atmosphere and services in the hospital for patients, families, and staff, as well as “community” benefits, such as fundraising events in collaboration with the surrounding community members to make a contribution to improve healthcare. There are also some individuals who may have had negative experiences as volunteers in the hospital, such as being burnt out or having a conflict with another individual.

While volunteering, participants can experience additional reasons to continue volunteering in the hospital, such as affection for their hospital and commitment to

volunteering. Volunteer retention can also be facilitated by several strategies (e.g. recognition of volunteers via appreciation lunches). Volunteer retention and the motivation to continue volunteering are represented by the double-sided arrow; older volunteers may keep volunteering longer as a result of retention strategies or motive to continue volunteering. At the same time, some older adults may be motivated to slow down or stop volunteering for several different personal reasons (e.g. health, and other commitments).

The major unexpected finding in this study is that there are also two contextual factors that influence these overarching themes in some manner. The Auxiliary Factor is indicated by the blue dotted line with the shaded pattern and the Change Factor is indicated by red-dashed line with a shaded pattern. As described throughout in this Chapter, since the Auxiliary Factor is a facilitator for social capital development and the benefits from volunteering, it is coloured blue. In contrast, the Change Factor is generally hindering to the development of benefits from volunteering and social capital, and it is thus coloured red. In addition, since the Change Factor can also influence the Auxiliary Factor, it encompasses the Auxiliary Factor in the diagram.

In summary, volunteering in the community hospital network was found to be a very beneficial activity for older adult participants in this study. They especially benefitted from the various relationships that they had developed with other people through their hospital volunteering. These relationships also benefitted patients, families, hospital staff, and community members. A unique feature of hospital volunteering is the existence of the hospital Auxiliary, created by volunteers. There was one Auxiliary per hospital, each one a formal organization with its own president, meetings for Auxiliary

members, events, and specific volunteer roles. This self-governed characteristic of Auxiliaries seemed to exude a very positive influence over most participants' experiences in the hospitals in this study. Many participants in this study echoed that the existence of the Auxiliaries facilitated them and their fellow older volunteers to create friendships, a sense of community, and their shared values such as caring and helping each other. The benefits generated from the strong bonding among Auxiliaries not only motivated the older volunteer participants' active social participation, but also spread out into the hospital and surrounding community levels. This Auxiliary Factor -- which augments the positive experiences of older volunteers -- is especially important, given the ongoing changes happening in the community hospital network (i.e. Change Factor). The social capital that Auxilians created for "their own" hospitals, not to mention their fundraising contributions, can play an invaluable role to counterbalance some of the negative effects of the reorganization of the smaller hospitals in the network.

In conclusion, I found four major themes that emerged from the study: reasons to volunteer, management's influence, negative experiences of volunteering, and connections with others. The first three themes answer the first research question on what older hospital volunteers' experiences are, while the fourth theme answers to the second research question on developing social capital. The following chapter will focus on comparing these findings to the existing literature on these topics.

Chapter 5: Discussion

This chapter will discuss the findings highlighted in chapter four. I will first explore the general overview of volunteers in this community hospital network.

Afterwards, I will discuss the four major themes: reasons to volunteer, management's influence, connections with others, and negative experiences of volunteering, as well as compare the findings in these themes to the existing literature.

Overview of Volunteers

The findings of my study on older volunteers in this community hospital network show some relatable volunteer trends to those in Ontario and Canada. It is noteworthy that the volunteers in this community hospital network were predominantly older, female, and retired. Only a quarter of the approximately 850 volunteers were students. A review of the literature would indicate that the volunteer rate for hospitals in Canada was only 3% for older adults, whereas in my findings the majority of hospital volunteers were older adults (Cook & Sladowski, 2013). This disparity may be due to this Southern Ontario region having a larger proportion of older adults (16.2%) than Ontario (12.7%) and Canada (12.9%), a percentage which is continuing to increase ([Region Name], 2014a; Statistics Canada, 2013b).

While older adults who were volunteering tended to be committed, the number of new older adults joining hospital volunteers in the community hospital network has been decreasing. This trend found in my study overlaps with the general trend of Canadian volunteers where they had a decreased chance of volunteering as they became older (e.g. those aged 65 years and older; Vézina & Crompton, 2012). If they do volunteer, however, the number of hours put into volunteering increases, similar to what was found in this

current study about older volunteers being committed (Hall et al., 2007; Vézina & Crompton, 2012). Older participants in the current thesis also considered health to be the main factor as to why an older adult may not take part in volunteering. The finding was similar to the results of a previous study that found that older Canadian volunteers listed health as one of the major reasons as to why they did not volunteer (Vézina & Crompton, 2012).

Over the years, the number of older volunteers and volunteers in general has been declining in this community hospital network. This is similar to the findings from Volunteer Canada (n.d.), which found from their surveys with individuals in administrative-level positions in Ontario that 17% felt their volunteers were aging, and that more volunteers were leaving because of age-related health complications.

However, I found that there is still a demand in the network for volunteers, specifically for those who are Auxiliary volunteers, willing to stay long-term, and willing to do “menial” roles. The research by Volunteer Canada (n.d.) found that though organizations knew it was becoming more difficult to find long term volunteers, approximately 49% of them were unsure of how to recruit the “new” short-term volunteer. It may be the case then that this network, due to changes in the commitment for new volunteers, may have to redefine their volunteer positions and roles in order to get them filled by this new group of volunteers. In summary this community hospital network does seem to be fairly similar to Ontario and Canada in regards to the changes seen in their older volunteers.

Reasons to Volunteer

Motivation to start volunteering. I found from my interviews that many of the

older adult volunteers were motivated internally to begin volunteering at their hospital. Some older adults wanted to volunteer in a healthcare setting as a result of previous skills or personal interest related to healthcare. A few participants talked about the desire to help others, such as taking care of their own community through their volunteering. Hence the internal motivations of older adult volunteers come from different sorts of “wants”. This finding overlaps with previous literature, which found a number of different reasons for older adults to engage in volunteering (Blanchard, 2006; Cook & Sladowski, 2013; Narushima, 2005; Zweigenhaft et al., 1996).

The motivations to volunteer in a specific location because of complimentary skillsets for that position, relates to the findings of Cook and Sladowski (2013) from the 2010 CSVGP, which also found that 82% of older volunteers were motivated to volunteer in order to use their existing experience and skills. Personal interest in healthcare as a motivation to volunteer relates to the previous work conducted by Narushima (2005) and Cook and Sladowski (2013), both of whom found that that older adults may be motivated to volunteer because of their own self-interests, or were personally affected by the specific cause that the organization supported.

In addition, I found that a few participants in this study discussed the want to help others as a motivation. The altruism reported by participants of the current thesis was akin to that found in volunteering populations that were examined in relevant literature (Blanchard, 2006; Cook & Sladowski, 2013; Narushima, 2005; Putnam, 2001; Zweigenhaft et al., 1996). In addition, Putnam (2001) states that social connectedness can predict altruism, which could indicate that stronger social connections (discussed further under “Connections with Others”) may result in older volunteers wanting to help and

give more to the local community.

The findings of the present study differs from that of Cook and Sladowski (2013) who found that more than half of the older adults wanted to volunteer to develop networks and meet new individuals. The current study focused on older adults, most of which have volunteered in many locations outside of the hospital. It is possible that they did not have developing networks as a motivation because they did not have a need for it, as they had already developed networks and relationships in other locations.

Motivation to continue volunteering. Volunteer participants also had different reasons to continue volunteering. I found that participants were motivated to continue volunteering mainly because of their affection for the hospital, and their commitment to volunteer. This is slightly different than Claxton-Oldfield and Claxton-Oldfield's (2012) study, which found that the main two reasons volunteers wanted to continue volunteering was to help or make a difference to others, and personal enjoyment. My findings are dissimilar than those of Claxton-Oldfield and Claxton-Oldfield (2012) due to the different volunteer positions. Most of my volunteers were Auxiliary members with roles involving fundraising and managing the gift shop, whereas in Claxton-Oldfield and Claxton-Oldfield's (2012) study all of the volunteers were involved in patient-oriented roles. The difference in the level of contact with patients and families may have contributed to the differing results. Nevertheless it seems that both this current study and Claxton-Oldfield and Claxton-Oldfield's (2012) study are similar in the sense that the volunteers attach importance to their volunteering and this in turn motivates them to volunteer.

In summary, the findings from the current thesis add to existing literature that

motivations to volunteer, and to continue volunteering, stem from a variety of internal reasons. The motivations that I found in my research are representative of reciprocity (Esmond & Dunlop, 2004; Gouldner, 1960 as cited in McMunn et al., 2009). Referring to the diagram at the end of Chapter 4, the motivations to volunteer seem to be akin to the “fuel” needed for older adults to get involved in, and continue volunteering in the hospital.

Management’s Influence

Recruitment. The findings from this current study suggested that there was a strong need in the hospitals for specific types of volunteers, such as Auxiliaries, who were willing to commit for long durations. These findings are comparable with what Handy and Srinivasan (2005) found in their study on hospital volunteers in Toronto. They discovered that hospitals were not in need of all volunteers, but rather, they were in need of volunteers to fill in specific roles, with the preference for long-term volunteers.

As Handy and Srinivasan (2005) found in their study, this current study also found that hospitals were having trouble finding volunteers willing to fill in unique roles. However, although Handy and Srinivasan’s (2005) study found that volunteer demand was a general downward slope, the findings of this current study suggested that volunteer demand was strong in the community health network’s hospitals. This may be because the participants of Handy and Srinivasan’s (2005) study consisted of volunteers with various roles in large urban hospitals, whereas most participants in this current study were Auxiliary volunteers, who largely volunteered in locations such as the gift shop, and were situated in relatively small sized hospitals. Since the older volunteer participants, especially Auxiliary volunteers, were exposed to the situations where there was a lack of

volunteers, they may have felt a strong need for hospitals to recruit more volunteers.

“Word-of-mouth” via other volunteers, was seen to be an effective recruiting strategy for potential older adult volunteers. This finding from my study is similar to the research by Nagchoudhuri et al. (2005) and the National Seniors Council (2010), which found that older adult volunteers were usually recruited through informal methods, such as when they were recruited through existing volunteers. The National Seniors Council (2010) stated the importance of considering the older adult population to be a unique group of volunteers who may not respond to recruitment strategies standardized for all volunteers, and encouraged informal recruitment strategies instead. The results of my current study also suggest the need for the focused recruitment suggested by the National Seniors Council (2010).

Volunteer retention and turnover. In this research project, I found volunteer retention was not an issue for older volunteers, especially considering their long retention period when compared to other volunteers such as students (generally a one year retention period). Nevertheless, health was seen by many of the participants to be a top reason which caused older volunteers to leave their position, followed by having other commitments. The literature exhibited numerous reasons for volunteers to stop or slow down their level of volunteering (Cook & Sladowski, 2013; Tang et al., 2010; Volunteer Canada, n.d.). The findings from this study were similar to previous studies in the sense that they also found older adults specifically stated declining health and other commitments or lack of time, as reasons to decrease or quit volunteering (Cook & Sladowski, 2013; Tang et al., 2010; Volunteer Canada, n.d.).

Concurrently, the results of this study also showed some differences from the

literature concerning reasons for volunteer turnover. For example, none of my findings gave any indication of the nine personal and program factors that were significant in estimating the turnover of volunteers (Tang et al., 2010). This may be because the participants in Tang et al.'s (2010) study also included those who had already stopped volunteering at the time of research, whereas my participants were still volunteering, and could only predict the reasons as to why individuals would stop or slow down volunteering. Thus it is possible that if I talked to volunteers who had already quit their volunteering, I may find reasons similar to Tang et al. (2010) as to why they quit. The findings of this study were also dissimilar to that of Volunteer Canada (n.d.). Volunteer Canada (n.d.) used a general Ontarian sample of residents, of which more than half were current volunteers. This may be the reason as to why they found additional factors, such as age, lack of opportunity, children growing up, and moving, which negatively affect volunteer retention (Volunteer Canada, n.d.). Several older volunteers in this study felt that volunteer recognition by the organization (e.g. holding appreciation lunches) was an important aspect of volunteer retention. This finding was similar to previous studies where researchers found that recognition by the organization such as verbal appreciation of their work, was a key factor in volunteers' motivation to continue in their position (Nagchoudhuri et al. 2005; Narushima 2005).

A few of my participants mentioned the positive effect that the Auxiliary had on volunteer recognition. To the best of my knowledge, there was little to no literature on the positive effects of the Auxiliary on increasing volunteer recognition. Some of the Auxiliary volunteer participants in my study stated that their Auxiliary organization held additional appreciation lunches on top of the ones given by volunteer management in the

community hospital network. These lunches were a form of volunteer recognition, which according to Nagchoudhuri et al. (2005), had a positive effect on volunteer retention.

Thus I have made an assumption that when the Auxiliary holds additional volunteer recognition events such as their appreciation lunches, this may positively affect volunteer retention. However more research is needed to understand the relationship between an increasing number of volunteer recognition events and volunteer retention. More research is also needed to determine whether there is a difference in volunteer retention, between whether the volunteer recognition events come from volunteer management or from the Auxiliary.

Negative Experiences of Volunteering

Though this was reported much less when compared to the positive experiences of hospital volunteering, the results of this study suggested there are some negative features inherent to volunteering. A few participants noted that “burn-out” was a reality for some of them. Some participants also shared the stories of those who had quit volunteering due to the negative experiences with other volunteers or patients. In addition, one participant hinted her occasional frustration about the hospital management when volunteers made some suggestions in vain.

The PHAC (n.d.) noted from their study that there is a risk of older volunteers becoming burnt out, especially when they are heavily relied upon by the organization that they work for. Those who were very actively involved in their positions seemed to feel the same way in my study. According to the Volunteer Canada (n.d.), nearly 40% of Ontario volunteers reported negative aspects of their volunteering such as interactions with rude individuals, politics, the type of work involved, poor organization, and a lack of

appreciation. My findings on older volunteers having difficult experiences with other volunteers and the hospital management partially overlaps with these findings.

Connections with Others

A key finding of my research is that hospital volunteering at the hospital network helps older volunteers develop social relationships with other individuals that vary in nature and degree of strength. Substantive literature has been written indicating that the act of volunteering cultivates social capital (Darcy et al., 2014; Putnam, 1995; Putnam, 2001; Peachey et al., 2015; Szreter & Woolcock, 2004). However little to no literature was found speaking to the three types of social capital (i.e. bonding, bridging, and linking) that could develop, particularly between older hospital volunteers. This seems to agree with the systematic reviews by Derose and Varda (2009) and Nyqvist et al. (2013), who state that including these three types of social capital in relation to health-related research was a fairly novel concept. Moreover, finding literature on the different degrees to which these three types of social capital could develop, was a particularly arduous process. Since I used a qualitative methodology, careful analysis of the participants' stories helped me notice the different degrees to which the three types of social capital were formed. It was interesting to note that the literature which mentioned the varying degrees of social capital developed through volunteering, was found in the discipline of sport management rather than public health, and those studies also used qualitative research methodologies (Burnett, 2006; Darcy et al., 2014; Peachey et al., 2015)

Bonding social capital and benefits. Older adult volunteers developed multiple relationships with other older volunteers in their hospital. This finding falls in line with that of the literature, namely that “bonding” social capital can develop between

individuals similar to each other in some capacity (Gittell & Vidal, 1998 as cited in McKenzie et al. 2013; Szreter & Woolcock, 2004). In the case of my findings, these similarities included age, views on volunteering, and the importance they attached to the hospitals in their own communities. In addition, being Auxiliary and their shared volunteer positions especially seemed to facilitate their bonding process. Older volunteers' bonding relationships were categorized as: "acquaintance", "close friendship within the hospital", and "close friendship beyond the hospital". I was unable to find literature that went in detail about the varying degrees of bonding among older volunteers at hospital settings. However, the findings of my study support and add additional knowledge to the body of literature, which found the development of bonding relationships among volunteers in diverse age groups in non-profit sports organizations or events (Burnett, 2006; Darcy et al., 2014; Peachey et al., 2015). Moreover, some of these community-based organizations shared some similar characteristics to a hospital, such as being a non-profit organization with a volunteer component to it (Darcy et al., 2014).

Older volunteers received psychological benefits from bonding relationships, such as feeling less alone and general feelings of happiness. This finding confirms previous literature by Kim et al. (2006), who found "protective effects" from community bonding and bridging social capital for individuals of all ages. It also adds to the literature that states having more social networks leads to more positive self-rated health for older adults, and relationships with long-term friends improves mental well-being for older adults (Forsman et al., 2013; Zunzunegui et al., 2004). Even with all these positive benefits from bonding relationships, I found however that the Change Factor, which in this case was the closing of one of the hospitals, had a negative effect on the dedicated

older volunteers' emotions.

There were also individual-level reciprocal benefits of bonding relationships, such as having someone else who could cover a shift if they were unable to volunteer one day. This finding relates to Putnam's (1995) definition of social capital which states that social capital can result in mutual benefit and social trust, alluding to the benefits received by both parties involved in the social capital development. These reciprocal benefits and the motivation to continue volunteering there to enact social change, is key in social capital development (Peachey et al., 2015).

Bridging social capital and benefits. Older adult volunteers created friendly and caring relationships with patients, families and individuals in the community surrounding the hospital. These types of relationships overlap with "bridging" social capital, which is created between people who are dissimilar, but still mostly equal in power and status (Gittell & Vidal, 1998 as cited by McKenzie et al., 2013; Szreter & Woolcock, 2004). Although older volunteers, patients, and their families are dissimilar from one another in their roles in the hospital, they are equal in terms of power and status as residents of the local community. Moreover, older volunteers are also users of the healthcare services at hospitals. Just as Peachey et al. (2015) alluded to the fact that bridging social capital can be developed to different degrees, the bridging relationships found in my study were categorized into three degrees: "small talk", "some friendships developed" and "close friendships".

The results of this study suggested the patients and families felt the hospital to be "comforting", and the individuals in the hospital to be "like family". This comfort may be an example of "social trust", a term used by Putnam (1995). Feelings of "comfort" and

having a sense of “family” in my findings may also be grouped into the broader term of psychological benefits for patients. In volunteer management literature, research has shown that volunteer involvement can improve patient satisfaction in hospitals (Handy & Srinivasan, 2004; Rogers et al., 2013).

The Auxiliary Factor had a strong role to play in the bridging relationships that benefitted the local community. After the closure of their local hospital (site F), that hospital’s Auxiliary decided to band together as a group and join the local healthcare network in order to maintain the quality of healthcare in their community. This example showed that the strong bonding network within the Auxiliary provided a foundation for cultivating strong bridging relationships, which in turn helped the dedicated Auxilians join and become a part of the local healthcare network. The findings from my study overlap with the study by Darcy et al. (2014), which found that bonding paved the way for bridging social capital to take place. This also provides additional supporting evidence to the literature that found volunteers to be an important positive “link” to the surrounding community (Handy & Srinivasan, 2004; Handy & Srinivasan, 2005; Putnam 1995; Rogers et al., 2013). My findings also mirror the results of the study which found that social capital built in one organization can expand into a larger network via the cooperation of other community organizations and members, and in turn benefit surrounding communities (Buys et al., 2010).

By developing connections with individuals in the community, the Auxilians were also able to create community-level reciprocal relationships. The strong relationships developed with community members were beneficial when the Auxiliary needed assistance for fundraising events in regards to supplies and equipment. This finding also

alludes to the development of relationships resulting in reciprocal benefits as seen in Putnam's (1995) definition of social capital.

Linking social capital and benefits. Older volunteer participants were able to form relationships with the staff (e.g. doctors, nurses) at the hospital to two degrees: “acquaintances”, and “some degree of friendship”. This finding confirms the existence of “linking” social capital between individuals who have “vertical” relationships with different levels of status and power (Elgar et al., 2011; McKenzie et al., 2013; Szreter & Woolcock, 2004). As with bonding and bridging social capital, I was unable to find literature on the varying degrees of linking social capital.

The findings of my study suggest that the benefits from linking social capital development were related back to hospital benefits. Older volunteers stated that these “friendly connections” between volunteers and hospital staff created an all-around positive atmosphere in the hospital. This supports the results of Handy and Srinivasan's (2004) study that found hospital staff felt volunteers increased patient care quality. I also found that this finding overlaps with the literature which highlights that linking relationships were built on trust between individuals of different status and power and are important to the individuals' well-being (Szreter & Woolcock, 2004). These relationships built on trust contribute to creating a positive atmosphere in the hospital, which results in the positive well-being of the staff, older adults, and patients in the hospital.

Factors influencing social capital development. I found that there are several different contextual factors that acted as facilitators or hindrances for the development of bonding, bridging, and linking social capital. This is an unexpected yet important finding of this qualitative case study. Depending on the hospital context, one factor could act as

both a facilitator and hindrance. My findings on these factors adds support to the results of previous studies which highlight that social capital development is affected by factors external to those involved in creating the social capital (Coleman, 1990; Peachey et al., 2015).

There were two large contextual factors that I termed the Auxiliary Factor and the Change Factor, which acted as a facilitator and hindrance respectively. These factors represent the environmental or structural factors which act as a broader context in which social capital development occurs. This finding supports the framework proposed by Health Canada (2006) used to analyze social capital development, which also takes into account the important effect that these broad contextual factors may have on social capital.

Facilitating factors. There were several broad factors that enabled the development of the three types of social capital in the hospital. These were the participants, the volunteer position and location, and the Auxiliary Factor. The general characteristics of “older volunteer” themselves (i.e. being able to get along with everyone, being very involved and devoted in volunteer activities) are a key facilitating factor. This partially relates to the Policy Research Initiative (PRI) Framework (2005) as cited in Health Canada (2006), where they state that there are “individual” level determinants (e.g. age, attitude, social participation) which affect social capital. I found from my research that older volunteers who were more “involved”, developed stronger social capital. Moreover, most older volunteers in my study were long-lasting volunteers, which also confirms that having long-term relationships leads to “shared life events” (Forsman et al., 2013, p. 820), which in turn strengthens social capital.

The volunteer position and corresponding location can act as both a facilitating and hindering factor depending on the context. If older volunteers were assigned in the location and role where they have opportunities to work with others (e.g. staff, other older volunteers, or interacting with patients), it strengthens linking, bonding, and bridging capital respectively. This finding partially confirms the research by Forsman et al. (2013) in a nursing home, which found that relationships between older adults was strengthened by their environment which facilitated their interactions.

The Auxiliary Factor was found to have an overall positive effect on the development of all three types of social capital. Active involvement in the Auxiliary through being on the executive team or taking part in Auxiliary events was seen to be a facilitator to stronger social capital in my study. While there was a lack of literature on the effects of Auxiliary membership for social capital development, my findings contribute to the vast amount of literature which states the importance of active participation in a social association like the Auxiliary, for social capital development (Darcy et al., 2014; Putnam, 1995; Putnam, 2001; Szreter & Woolcock, 2004; Peachey et al., 2015).

Hindering factors. There were several factors that hindered the development of social capital by older volunteer participants. Though these factors slightly differed between the three types of social capital, I have grouped all of them under what I have termed the “Change Factor”. As I described in the Chapter 4, the Change Factor includes various hospital conditions (e.g. closing or downsizing of the hospital), resulting from the ongoing alterations in the hospital network. This dynamic contextual “change” was found in most cases to hinder the development of social capital by older volunteers.

The study conducted by Peachy et al. (2015) mirrored findings of this thesis as they found that the context in which social capital occurs can act as a hindering factor in its development, showing an example of a negative case where an organization did not provide their volunteers with enough support to help them develop connections with other individuals. The lack of the community organization acting as a facilitator seemed to stop the progression of stronger social capital from forming (Peachey et al., 2015). In my study, as hospital downsizing resulted in less jobs and roles for volunteers in general, this reduced the chances of older volunteers interacting with one another, which affected bonding social capital. In addition, hospital downsizing resulted in a reduced patient length of stay, which in turn affected bridging social capital development. Moreover, it reduced the chance for additional linking social capital through decreasing the number of staff such as doctors, and closing common areas such as the cafeteria where older volunteers could interact with hospital staff. If the organization was able to play a role in supporting the social capital development between individuals (e.g. such as additional volunteer events), this may decrease damages of the Change Factor on social capital development (Peachey et al., 2015).

This chapter provided a discussion of my findings with the past literature. I focused on the general overview of volunteers in this Southern Ontario community hospital network compared to those in Ontario and Canada, the reasons to volunteer, management's influence, negative experiences of volunteering, and the development of connections with others. The following chapter will tie together the key findings of this study and discuss implications for future research and practice.

Chapter 6: Conclusion

This chapter will provide a summary and highlight the major findings of this research project. It will also discuss several limitations and strengths of the study, and examine implications for future research and future practice, as well as my own thoughts as the researcher and some conclusive remarks.

Summary of the Study

The purpose of this study was to explore the 10 older adults' volunteering in a community hospital network in Southern Ontario. I decided to focus on older volunteers because of the existing societal-wide perception that older adults will burden the healthcare system (CFHI, 2011; CMA, 2010). Moreover, I wanted to explore how older adults may be contributing back to the healthcare system through their volunteer work, and how this active community engagement benefits them as well. This region in Southern Ontario was central to this thesis because of its increasing number of older adults, having one of the highest proportions of older adults (who are 65 and older) in Canada ([Region Name], 2014a; Statistics Canada, 2013b). This large group of older adults with various life experiences and skills could be a potential pool of volunteers for healthcare organizations in the community. In addition, this region has also been working on its Age-Friendly Community Initiative, which could be benefitted from engaging older adults as volunteers in its community hospital network ([Region Name], 2014c). I focused on hospital volunteers because of the importance that hospitals have in the Canadian healthcare system.

In order to understand the 10 older adults' volunteering in this hospital network, I attempted to address the two main objectives of my research: (a) to explore the

experiences associated with these older adults' volunteering; (b) to understand if and how volunteering helped develop social capital for older adults. Having employed a qualitative case study methodology, I conducted in-depth face-to-face interviews with 10 active older volunteers recruited across six hospitals in the network, while using document analysis and a key informant interview for the purpose of data triangulation. The results consisted of four major overarching themes, namely: (a) reasons to volunteer; (b) management's influence; (c) connections with others; (d) negative experiences of volunteering. Based on the findings, three points were emergent as key lessons learned from this case study.

The first key point from this study is the significant contributions of older volunteers to the community hospital network, seen through the strong commitment and enthusiasm of older volunteers to support their own hospitals. The number of volunteers in the network, including older volunteers, has been on a decline over the last several years. The hospitals have a need for volunteers who are committed for the long term, want to be part of the Auxiliary, and/or be able to carry out roles that may seem menial to others. Though older adults might fill in some of these needed roles, the hospital network currently uses no specific recruitment strategies that target this untapped volunteer resource. Older adults began volunteering as a result of internal motivations, while their motivation to continue volunteering came from a strong affection for their hospital and commitment to volunteering. Older volunteers had long retention times, and did not leave their volunteering role until they got to the point where their health would not let them continue, or when they had to leave to take care of family and friends. This implies that once older people put their feet in the water of volunteering, their chance of becoming

dedicated contributors to their local hospital was high.

The second key point is that volunteering at the hospitals boosts the development of all three types of social capital (bonding, bridging, and linking) for older adults. Bonding social capital was created with other older volunteers, bridging social capital was created with patients, families and the surrounding community, and linking social capital was created with the hospital staff. Older volunteer participants were seen to develop all three types of social capital, and each type of social capital was created in varying degrees. Moreover, bonding social capital seemed to be the foundation needed to enhance the development of bridging social capital. The development of these three types of social capital brought about numerous positive influences on the experiences of older adult volunteers, the patients and their families, community members, and the hospitals. In particular, these positive benefits arising from its development, seemed to act as a “buffer” for the negative experiences that older adults occasionally have had as hospital volunteers. Therefore, although negative experiences are an unavoidable aspect of volunteering, its effects on the volunteers can be mitigated by the benefits of social capital.

The third key point was the existence of the overarching Auxiliary and Change Factors, and how they both played significant roles on the overall experiences of older volunteers at the hospitals, including their social capital development. The Auxiliary was an independently-managed organization within the hospital composed solely of older volunteers. They had their own rules, executive committee, general meetings, volunteer roles, and had “ownership” of some amenities in the hospital (e.g. gift shop). This organization acted as a key enabling factor that positively affected the older volunteers’

chances and abilities to develop social capital with others, which in turn resulted in benefits for all individuals involved. The Change Factor, on the other hand, was seen by the majority of participants to be a negative influence on their volunteer experience. It was responsible for hindering the development of social capital, and hence the benefits from this development. These two contextual factors emerged multiple times in various forms throughout this research when the participants talked about different aspects of their volunteer experiences. This fact in itself suggests the strong influence of the Change and Auxiliary Factors perceived by older volunteers on their volunteer experiences.

Limitations and Strengths

This study has a few limitations. First, as an observation method was not included, I am limited to the data which was obtained from my in-depth interviews and document analysis to see how older adults actually engaged in their volunteer activities and developed different types of social capital. As a result, I may have encountered a slight bias in my findings due to the participants' social desirability when conducting the interviews. The lack of influence from varying demographic characteristics could also be considered a limitation of my study. Although I obtained several demographic characteristics, they did not seem to influence my findings in any manner. For example, I examined whether marital status influenced the benefits received by participants for developing connections with others through their volunteering. Both groups of participants, those who were single or widowed, and married or living with a partner, all benefitted from developing relationships. As my sample consisted of only 10 participants who were rather homogeneous, my findings were inconclusive in determining if one group of participants received much greater benefits from developing these relationships.

Even with these limitations however, this qualitative case study has several unique strengths that should be highlighted. These include the characteristics of the participants, and the use of a qualitative methodology and methods. My final sample was a total of 10 participants who were all female and over the age of 65 years. While the lack of diversity in the study participants was an unplanned limitation of my study, it was simultaneously one of the greatest strengths. For instance, the high concentration of older female volunteers helped me to understand their unique volunteer experience at this community hospital network where the majority of older volunteers were females. Moreover, as eight out of ten of my participants were Auxiliary members, I was able to obtain rich data on the unique roles and experiences of the hospital Auxiliary, which is still a relatively unstudied topic, despite its long history. Since Auxiliaries exist in many hospitals across Canada as well as in some other countries, the findings of my study can be transferable to other Auxiliaries and their hospitals.

Another strength of my study is employing the use of qualitative research methods. Some literature has suggested to use qualitative research methods in order to thoroughly understand the concept of social capital (Derose & Varda, 2009). By using a qualitative case study approach and inductive analysis, I was able to find in-depth and context-rich information on the older volunteers' experiences, social capital development, as well as the dynamic contexts in the community hospital network. Furthermore, by analyzing this rich qualitative data, I could also find the varying degrees to which each of the three types of social capital were developed, and that older adult volunteers showed a lot of concern and care for each other, the patients and their families that came into the hospital, and their local community. As such, I was able to capture and illuminate this

cognitive aspect of social capital, in addition to the structural components seen in the type and strength of relationships developed. Thus my research, through using a qualitative approach, is able to add to the lack of literature on elements of both cognitive and structural social capital developed by older volunteers in hospital settings.

The third strength is the geographic and temporal scope covered in the findings of this study. Though this case study focused on older volunteers' experiences in a community hospital network in a single region in Southern Ontario, geographic and contextual diversity of the hospitals within the region was one of the challenges for conducting this case study. However, by including participants from six different hospitals located in different municipalities in the region, I could find the very different conditions facing each hospital depending its location, and managed to incorporate them into my findings. Moreover, though it was not the intent of the research to include a specific temporal boundary, most participants talked about their recent experiences with the hospital network's reorganization. Thus I was able to unexpectedly capture the older volunteers' experiences within this period of change for the hospital network.

Implications for Future Research

As this study was mainly exploratory in the field of social capital development, I hope that it will be able to add to the following knowledge gaps identified in the social capital literature. There is a lack of literature on social capital in healthcare settings such as hospitals. My research focused on a group of volunteers in the hospital, who were generally Auxiliary members and thus had different volunteer roles than those who were in patient-oriented positions. In addition, I found that one of the facilitating and hindering factors which affected social capital development, was the volunteer's position. As my

study mainly explored social capital development by Auxiliary volunteers, perhaps future research can further delve into whether different volunteer positions in hospitals have different impacts on social capital development.

There is also a lack of research on how the three types of social capital can be developed to varying degrees. Thus this study contributed to the growing body of literature on different types of social capital developed by older hospital volunteers, as well as on the varying degrees to which each type of social capital can be created. I developed my own form of labelling these degrees, however it is unknown whether my labelling will be utilized in future research studies. It is important then to find a reliable labelling system for the varying degrees of social capital. Future research questions can include how the different degrees of each type of social capital can be measured. In addition, while there is extensive literature on the benefits of social capital in general, there seems to be a shortage of literature on linking social capital and its benefits. My research was able to find benefits for the hospitals as a result of the interaction between older volunteers and staff, but it was not clear if such linking social capital also benefitted the older volunteers or hospital staff. Thus future studies can explore the benefits for the individuals who take part in creating linking social capital.

This context-rich qualitative case study is novel in the sense that it put focus on and acknowledged how contextual factors (i.e. Auxiliary Factor and Change Factor) may have affected the development and benefits of social capital. It is essential then in future research endeavours to determine how unique contextual factors, may influence social capital development.

There are also a few implications for future research in regards to the participants.

For instance, further research can examine whether the positive influence of the Auxiliary Factor for the older female volunteers in this study is also spread to non-Auxiliary volunteers. Moreover, my study did not find differences in social capital development and its effects on older volunteers as a result of their demographic characteristics. Thus future research can delve into how these characteristics may have an effect on older adults' hospital volunteering and their social capital development. As my participants were all female, there is also a need for further gender-based analysis of the findings. It is possible that as the voices of the male volunteers were unavailable, the suggestions for practical recruitment and retention implications may not be relevant to them.

Implications for Future Practices

The practical implications of this research include: suggestions to improve further recruitment of long-term and committed volunteers, benefits as a result of these volunteers for the hospital and local communities, and the encouragement of active aging.

Older adults, once they became volunteers, were found to be very dedicated to their hospital, not leave unless it was completely necessary to do so, and filled in the roles that were in current demand by the community hospital network. Thus a recommendation for future volunteer management practices is to focus recruitment on this group of individuals to satisfy the hospital's demand for volunteers. This recommendation is similar to the finding by the National Seniors Council (2010), where older adults were found to be a vast volunteer resource that organizations have not yet made full use of. Volunteer participants in my study indicated that "word-of-mouth" could be used as a recruiting strategy for older adult volunteers. In regards to improving volunteer recruitment, the Auxiliary seems to be composed of a strong network of individuals, who

have developed relationships with several community members, including other older individuals through the members' other volunteer positions. Given that "word-of-mouth" is an effective strategy, it is possible that the Auxiliary taking a role in the hospital's recruitment strategy may in turn help the hospital target this older cohort of individuals to become volunteers. Though the purpose of qualitative research is not to be generalizable, the findings from this study, especially considering that the majority of the participants were Auxiliary volunteers, could be transferable to other hospital sites which also have Auxiliaries. The suggestions from this research for future practices, particularly in relation to including the Auxiliary in the recruitment process, are applicable to a large number of hospitals both inside and out of Canada.

By recruiting older adults into hospital volunteering, this community hospital network is engaged in promoting the active aging process. Providing more opportunities for older adults to partake in volunteering also delivers mutual benefits for the surrounding community and hospital as well (PHAC, n.d.; WHO, 2002). It allows older adults to contribute back to their own community through engaging in activities that directly support other community members, which improves the community's overall well-being (PHAC, n.d.; WHO, 2002). Moreover, as continuous social participation predicts positive self-rated aging, this also may benefit the community hospital network through decreased expenses as a result of improved health of the community's older adults (Bennett, 2005; Ichida et al., 2013; Mendes de Leon, 2005). In order to sustain and optimize these existing hospital volunteers, this community hospital network should keep embracing its older volunteers by enhancing facilitating factors for their social capital development, minimizing the negative effects of the Change Factor, and use targeted

recruitment strategies. Previous literature has also stated that it is important for the government and organizations to both be involved in this active aging process to benefit older adults and combat negative attitudes towards older adults (CHSRF, 2011; Revera Inc., n.d.; WHO, 2002). Thus it is important for the hospitals in this community hospital network to be involved in the active aging process. The findings of this research will help not only this hospital network, but also other community organizations who might want to engage older adults as volunteers and thus help them actively age.

Conclusive Remarks

The large number of older volunteers in this hospital network, especially in the Auxiliaries, suggests that the organization has been playing a successful role in promoting active aging. The WHO's Active Ageing Framework encourages the optimal aging of all older adults through activities such as volunteering to develop social support (WHO, 2002). As one ages, people may be more prone to losing their social connections and networks, which may put them into social isolation predicative of poor health outcomes (City of Brantford, 2008; Cornwell & Waite, 2009; House et al., 1988 as cited in Cornwell & Waite, 2009; Coyle & Dugan, 2012; Seeman et al., 1987; WHO, 2002). The effects of social isolation could be mitigated however by increasing volunteer opportunities for older adults in their local communities (PHAC n.d.; WHO, 2007). Being able to see older adults volunteering in the hospital, may also help combat negative attitudes that older adults are just burdening the healthcare system.

Overall, older volunteers are important, integral, and essential aspects of the hospital. This is a sentiment echoed by my participants. Volunteers improve the quality of patient visits, create a positive atmosphere in the hospital, and make multiple

connections with the surrounding community. This periphery helps hospitals transform into welcoming and supportive hubs in their communities, and is just as important as the tangible medical care services that hospitals provide. I strongly believe that the findings of this study can be used to help organizations and governments uncover new methods to help provide opportunities for older adults to actively age in their community.

References

- Aldwin, C.M., & Gilmer, D.F. (2004). *Health, illness, and optimal aging: Biological and psychological perspectives*. Thousand Oaks: Sage Publications Inc.
- Anderson, N.D., Damianakis, T., Kröger, E., Wagner, L.M., Dawson, D.R., Binns, M.A., Bernstein, S., Caspi, E., Cook, S.L., & The BRAVO Team. (2014). The benefits associated with volunteering among seniors: A critical review and recommendations for future research. *Psychological Bulletin*, 140(6), 1505. doi: 10.1037/a0037610
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *Qualitative Report*, 13(4), 544-559.
Retrieved from <http://nsuworks.nova.edu/tqr/vol13/iss4/2>
- Bennett, K.M. (2005). Social engagement as a longitudinal predictor of objective and subjective health. *European Journal of Ageing*, 2(1), 48-55. doi: 10.1007/s10433-005-0501-z
- Berger, P.L., & Luckmann, T. (1966). *The social construction of reality*. New York: Doubleday & Company Inc.
- Blanchard, J.A. (2006). Hospital volunteers: A qualitative study of motivation. *The International Journal of Volunteer Administration*, 24(2), 31-40. Retrieved from http://www.ijova.org/PDF/VOL24_NO2/IJOVA_VOL24_NO2_Blanchard_HospitalVolunteers.pdf
- Bryman, A., Teevan, J., & Bell, E. (2009). *Social research methods* (2nd ed.). Don Mills: Oxford University Press.
- Burnett, C. (2006). Building social capital through an 'active community club'.

International Review for the Sociology of Sport, 41(3-4), 283-294. doi: 10.1177/1012690207078381

Butler-Jones, D. (2010). The Chief Public Health Officer's report on the state of public health in Canada. Retrieved from http://www.phac-aspc.gc.ca/cphorsphc-respcacs/p/2010/fr-rc/pdf/cpho_report_2010_e.pdf

Buys, D. R., Marler, M. L., Robinson, C. O., Hamlin, C. M., & Locher, J. L. (2011). Recruitment of volunteers for a home-delivered meals programme serving homebound older adults: a theoretically derived programme among faith communities. *Public Health Nutrition*, 14(8), 1473-1478. doi: 10.1017/S1368980010002880

Canadian Foundation for Healthcare Improvement. (2011). *Myth: The aging population is to blame for uncontrollable healthcare costs*. Retrieved from <http://www.cfhi-fcass.ca/SearchResultsNews/2011/02/22/f20f6cb8-bfd0-453e-b470-6fb63c93a629.aspx>

Canadian Health Services Research Foundation. (n.d.). *Better with age: Health systems planning for the aging population: A background*. Retrieved from http://www.cfhi-fcass.ca/sf-docs/default-source/planning-for-the-aging-population-files/AR_Briefing_ENG.pdf?sfvrsn=0

Canadian Health Services Research Foundation. (2011). *Better with age: Health systems planning for the aging population: Synthesis report*. Retrieved from http://www.cfhi-fcass.ca/Libraries/Aging_roundtable_reports/0604-AGING_RNDTBLE-SNTHSS_FinalWEB.sflb.ashx

Canadian Institute for Health Information. (2011). *Health care in Canada, 2011 – A focus*

on seniors and aging. Retrieved from <https://secure.cihi.ca/estore/productFamily.htm?pf=PFC1677&lang=fr&media=0>

Canadian Institute for Health Information. (2013). *National health expenditure trends, 1975 to 2013*. Retrieved from https://secure.cihi.ca/free_products/NHEXTrendsReport_EN.pdf

Canadian Medical Association. (2010). *10th annual national report card on health care*. Retrieved from https://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/2010/report_card/2010-National-Report-Card_en.pdf

City of Brantford. (2008). *A master aging plan for Brantford & the County of Brant*. Retrieved from http://www.brant.ca/ourcounty/community_services/MasterAgingPlan.pdf

Claxton-Oldfield, S., & Claxton-Oldfield, J. (2012). Should I stay or should I go: A study of hospice palliative care volunteer satisfaction and retention. *American Journal of Hospice & Palliative Medicine*, 29(7), 525-530. doi: 10.1177/1049909111432622

Coleman, J.S. (1990). *Foundations of social theory*. US: President and Fellows of Harvard College.

Cook, S.L., & Sladowski, P.S. (2013). *Volunteering and older adults*. Retrieved from <http://volunteer.ca/content/volunteering-and-older-adults-final-report>

Cornwell, E.Y., & Waite, L.J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior*, 50(1), 31-48. doi: 10.1177/002214650905000103

Coyle, C.E., & Dugan, E. (2012). Social isolation, loneliness and health among older

adults. *Journal of Aging and Health*, 24(8), 1346-1363. doi: 10.1177/0898264312460275

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed-methods approaches* (3rd ed.). Thousand Oaks, CA: Sage. (Chapter 2: Pages 3-22.)

Darcy, S., Maxwell, H., Edwards, M., Onyx, J., & Sherker, S. (2014). More than a sport and volunteer organisation: Investigating social capital development in a sporting organisation. *Sport Management Review*, 17(4), 395-406. doi: 10.1016/j.smr.2014.01.003

Deroose, K.P., & Varda, D.M. (2009). Social capital and health care access: A systematic review. *Medical Care Research and Review*, 66(3), 272-306. doi: 10.1177/1077558708330428

Elgar, F.J., Davis, C.G., Wohl, M.J., Trites, S.J., Zelenski, J.M., & Martin, M.S. (2011). Social capital, health and life satisfaction in 50 countries. *Health and Place*, 17(5), 1044-1053. doi: 10.1016/j.healthplace.2011.06.010

Employment and Social Development Canada. (2014). Indicators of well-being in Canada. Retrieved from <http://www4.hrsdc.gc.ca/d.4m.1.3n@-eng.jsp?did=16>

Esmond, J., & Dunlop, P. (2004). Developing the Volunteer Motivation Inventory to assess the underlying motivational drives of volunteers in Western Australia. Retrieved from <http://volunteer.ca/content/clan-wa-inc-developing-volunteer-motivation-inventory-assess-underlying-motivational-drives>

Field, J. (2008). *Social capital* (2nd ed.). New York: Routledge.

Forsman, A.K., Herberts, C., Nyqvist, F., Wahlbeck, K., & Schierenbeck. (2013). Understanding the role of social capital for mental wellbeing among older adults.

- Ageing & Society*, 33(5), 804-825. doi: 10.1017/S0144686X12000256
- Gilmour, H. (2012). Social participation and the health and well-being of Canadian seniors. *Health Reports*, 23(4). Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2012004/article/11720-eng.htm>
- Hall, M., Lasby, D., Ayer, S., & Gibbons, W.D. (2007). *Caring Canadians, involved Canadians: Highlights from the Canada Survey of Giving, Volunteering and Participating*. Retrieved from <http://www.statcan.gc.ca/pub/71-542-x/71-542-x2009001-eng.pdf>
- Handy, F., & Srinivasan, N. (2004). Valuing volunteers: An economic evaluation of the net benefits of hospital volunteers. *Nonprofit and Voluntary Sector Quarterly*, 33(1), 28-54. doi: 10.1177/0899764003260961
- Handy, F., & Srinivasan, N. (2005). The demand for volunteer labor: a study of hospital volunteers. *Nonprofit and Voluntary Sector Quarterly*, 34(4), 491-509. doi: 10.1177/0899764005278037
- Haynes, P. J. (2009). Before going any further with social capital: Eight key criticisms to address. (Working Paper No. 02). Retrieved from http://digital.csic.es/bitstream/10261/14203/1/Before_Going_Any_Further_With_Social_Capital_Eight_Key_Criticisms_to_Address%5B1%5D.pdf
- Health Canada. (2006). Social capital and health: Maximizing the benefits. Retrieved from <http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2006-capital-social-capital/index-eng.php>
- Ichida, Y., Hirai, H., Kondo, K., Kawachi, I., Takeda, T., & Endo, H. (2013). Does social participation improve self-rated health in the older population? A quasi-

- experimental intervention study. *Social Science & Medicine*, 94, 83-90. doi: 10.1016/j.socscimed.2013.05.006
- Israelson, D. (2014, February 25). Ready to Retire? Leave the City and Upsize in [Region Name]. *The Globe and Mail*. Retrieved from [The Globe and Mail website]
- Johnson, K.J., & Mutchler, J.E. (2014). The emergence of a positive gerontology: From disengagement to social involvement. *The Gerontologist*, 54(1), 93-100. doi: 10.1093/geront/gnt099
- Kim, D., Subramanian, S.V., Kawachi, I. (2006). Bonding versus bridging social capital and their associations with self rated health: a multilevel analysis of 40 US communities. *Journal of Epidemiology and Community Health*, 60(2), 116-122. doi: 10.1136/jech.2005.038281
- Liamputtong, P. (2009). *Qualitative Research Methods* (3rd ed.). Australia: Oxford University Press.
- Martinson, M., & Halpern, J. (2011). Ethical implications of the promotion of elder volunteerism: a critical perspective. *Journal of Aging Studies*, 25(4), 427-435. doi: 10.1016/j.jaging.2011.04.003
- Mendes de L. (2005). Social engagement and successful aging. *European Journal of Ageing*, 2(1), 64-66. doi: 10.1007/s10433-005-0020-y
- Merriam, S. (2009). *Qualitative case study research. A guide to design and implementation*. San Francisco, CA: John Wiley & Sons, Inc.
- McKenzie, J.F., Neiger, B.L., & Thackeray, R. (2013). *Planning, implementation, & evaluating health promotion programs: A primer*. (6th ed.). Toronto, ON: Pearson.

McMunn, A., Nazroo, J., Wahrendorf, M., Breeze, E., & Zaninotto, P. (2009).

Participation in socially-productive activities, reciprocity and wellbeing in later life: Baseline results in England. *Ageing and Society*, 29(5), 765-782. doi: 10.1017/S0144686X08008350

Morrow-Howell, N., Hong, S.I., & Tang, F. (2009). Who benefits from volunteering?

Variations in perceived benefits. *The Gerontologist*, 49(1), 91-102. doi: 10.1093/geront/gnp007

Nagchoudhuri, M., McBride, A. M., Thirupathy, P., Morrow-Howell, N., & Tang, F.

(2005). Maximizing elder volunteerism and service: Access, incentives, and facilitation. *The Journal of Volunteer Administration*, 23, 11-14. Retrieved from http://www.ijova.org/PDF/VOL24_NO5/IJOVA_VOL24_NO5_Madhura.pdf

Narushima, M. (2005). 'Payback time': Community volunteering among older adults as a

transformative mechanism. *Ageing and Society*, 25(4), 567-584. doi: 10.1017/S0144686X05003661

National Seniors Council. (2010). *Report of the National Seniors Council on volunteering*

among senior citizens and positive and active aging. Retrieved from http://www.seniorscouncil.gc.ca/eng/research_publications/volunteering.pdf

[Region Name]. (2014a). *[Region name's] demographics*. Retrieved from [Region website]

[Region Name]. (2014b). *Aging well in [Region name] – A conversation about the needs of seniors*. Retrieved from [Region website]

[Region Name]. (2014c). *[Region name] age-friendly community initiative*. Retrieved from [Region website]

- Nyqvist, F., Forsman, A.K., Giuntoli, G., & Cattan, M. (2013). Social capital as a resource for mental well-being in older people: A systematic review. *Aging & Mental Health*, 17(4), 394-410. doi: 10.1080/13607863.2012.742490
- Public Health Agency of Canada. (n.d.). *Age-friendly rural and remote communities: A guide*. Retrieved from <http://www.phac-aspc.gc.ca/seniors-aines/publications/public/afc-caa/rural-rurales/index-eng.php>
- Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of democracy*, 6(1), 65-78. doi: 10.1353/jod.1995.0002
- Putnam, R. D. (2001). Social capital: Measurement and consequences. *Canadian Journal of Policy Research*, 2(1), 41-51. Retrieved from <https://search.oecd.org/edu/innovation-education/1825848.pdf>
- Revera Inc. (n.d.). *Revera report on ageism*. Retrieved from <http://www.reveraliving.com/About-Us/Corporate-Social-Responsibility/Community-Involvement/Age-is-More.aspx>
- Robertson, A. (1997). Beyond apocalyptic demography: Towards a moral economy of interdependence. *Aging and Society*, 17(4), 425-446. doi: 10.1017/S0144686X97006521
- Rogers, S.E., Rogers, C.M., & Boyd, K.D. (2013). Challenges and opportunities in healthcare volunteer management: Insights from volunteer administrators. *Hospital Topics*, 91(2), 43-51. doi: 10.1080/00185868.2013.806012
- Schoklitsch, A., & Baumann, U. (2012). Generativity and aging: A promising future research topic? *Journal of Aging Studies*, 26(3), 262-272. doi: 10.1016/j.jaging.2012.01.002

- Scott, J.P., Reifman, A., Mulsow, M., & Feng, D. (2003). Program evaluation of “Young at Heart”: Examining elderly volunteers’ generativity. *Journal of Intergenerational Relationships*, 1(3), 25-33. doi: 10.1300/J194v01n03_03
- Seeman, T.E., Kaplan, G.A., Knudsen, L., Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County study. *American Journal of Epidemiology*, 126(4), 714-723.
- Service Canada. (2014). Old age security pension. Retrieved from <http://www.servicecanada.gc.ca/eng/services/pensions/oas/pension/index.shtml>
- Sinha, S. K. (2013). *Living longer, living well: Highlights and key recommendations*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy.pdf
- Statistics Canada. (2010). *Population projections for Canada, provinces and territories*. Retrieved from <http://www.statcan.gc.ca/pub/91-520-x/91-520-x2010001-eng.htm>
- Statistics Canada. (2013a). *Annual demographic estimates: Canada, provinces and territories*. Retrieved from <http://www.statcan.gc.ca/pub/91-215-x/91-215-x2013002-eng.pdf>
- Statistics Canada. (2013b). *[Region name] regional area health unit (health region), Ontario and Canada (table). Health profile*. Retrieved from <http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E>
- Statistics Canada. (2015). *Canada’s population estimates: Age and sex, July 1, 2015*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/150929/dq150929b-eng.htm>
- Subramanian, S.V., Kim, D.J., & Kawachi, I. (2002). Social trust and self-rated health in

- US communities: a multilevel analysis. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 79(4). doi: 10.1093/jurban/79.suppl_1.S21
- Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33(4), 650-667. doi: 10.1093/ije/dyh013
- Tang, F., Morrow-Howell, N., Choi, E. (2010). Why do older adult volunteers stop volunteering? *Ageing and Society*, 30(5), 859. doi: 10.1017/S0144686X10000140
- Turcotte, M., & Schellenberg, G. (2007). *A portrait of seniors in Canada*. Retrieved from <http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf>
- VanWynsberghe, R., and Khan, S. (2007). Redefining case study. *International Journal of Qualitative Methods*, 6(2), 80-94. Retrieved from <https://ejournals.library.ualberta.ca/index.php/IJQM/article/viewFile/542/2495>
- Vézina, M. & Crompton, S. (2012). *Volunteering in Canada*. Retrieved from <http://www.statcan.gc.ca/pub/11-008-x/2012001/article/11638-eng.pdf>
- Volunteer Canada. (n.d.). *Bridging the gap in Ontario: A profile of current trends in volunteering*. Retrieved from <http://volunteer.ca/content/bridging-gap-ontario>
- Volunteer Canada. (2012). *The Canadian code for volunteer involvement: Values, guiding principles and standards of practice*. Retrieved from <http://volunteer.ca/content/canadian-code-volunteer-involvement>
- Wahrendorf, M., Knesebeck, O. von dem., & Siegrist, J. (2006). Social productivity and well-being of older people: Baseline results from the SHARE study. *European Journal of Ageing*, 3(2), 67-73. doi: 10.1007/s10433-006-0028-y
- Peachey, J.W., Bruening, J., Lyras, A., Cohen, A., & Cunningham, G.B. (2015).

- Examining social capital development among volunteers of a multinational sport-for-development event. *Journal of Sport Management*, 29(1), 27-41. doi: 10.1123/JSM.2013-0325
- Wilson, J. (2000). Volunteering. *Annual Review of Sociology*, 26(1), 215-240. doi: 10.1146/annurev.soc.26.1.215
- Wilson, J., & Musick, M. (1997). Who cares? Toward an integrated theory of volunteer work. *American Sociological Review*, 694-713. doi: 10.2307/2657355
- Woolcock, M., & Narayan, D. (2000). Social capital: Implications for development theory, research, and policy. *The World Bank Research Observer*, 15(2), 225-249. doi: 10.1093/wbro/15.2.225
- World Health Organization. (2002). *Active ageing: A policy framework*. Retrieved from http://whqlibdoc.who.int/hq/2002/who_nmh_nph_02.8.pdf
- World Health Organization. (2007). *Global age-friendly cities: A guide*. Retrieved from http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf
- World Health Organization. (2009). *WHO global network of age-friendly cities*. Retrieved from <http://www.who.int/ageing/Brochure-EnglishAFC9.pdf>
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Zaninotto, P., Breeze, E., McMunn, A., & Nazroo, J. (2013). Socially productive activities, reciprocity and well-being in early old age: Gender-specific results from the English Longitudinal Study of Ageing (ELSA). *Population Ageing*, 5, 47-57. doi: 10.1007/s12062-012-9079-3

Zunzunegui, M.V., Koné, A., Johri, M., Béland, F., Wolfson, C., & Bergman, H. (2004).

Social networks and self-rated health in two French-speaking Canadian community dwelling populations over 65. *Social Science & Medicine*, 58(10), 2069-2081. doi: 10.1016/j.socscimed.2003.08.005

Zweigenhaft, R.L., Armstrong, J., Quintis, F., & Riddick, A. (1996). The motivations and

effectiveness of hospital volunteers. *The Journal of Social Psychology*, 136(1), 25-34. doi: 10.1080/00224545.1996.9923026

Table 5

Non-Auxiliary Volunteer Roles

Volunteer Location	Positions and Roles
Office	<ul style="list-style-type: none"> • “hub for the volunteers” • Where coordinators are when they are on site • Inputting volunteers’ hours • Replying to voice mails • Booking pre-natal tours • Tabulating statistics
Information/Front Desk	<ul style="list-style-type: none"> • Check doctor off of list and directs them to where they need to go • Tell patients where they need to go • Tell visitors where patients are located • Sell tickets
Clinic	<ul style="list-style-type: none"> • Where procedures are done by surgeons • In a “clinic unit” where all doctors come in on different days to do their procedures • Put charts together • Ask patients to sign consent and medical history forms • Look after patients that come in
Emergency	<ul style="list-style-type: none"> • Directs patients to where they need to go
Operating Room	<ul style="list-style-type: none"> • Volunteers work in the patient waiting area • Take patient’s chart to nurses • Bring patient to the back to get prepared for surgery • Talk to family members about how to follow the tracking board • Bring family member to post-recovery room after operation is complete • Find out which floor patient will be discharged to after operation • Bring family members into privacy room, where doctors go to if need to talk to family members
ICU	<ul style="list-style-type: none"> • Clean pans • Give out water • Converse with patients • “doing the bundles” • Clean and make up the beds

	<ul style="list-style-type: none"> • Give out bed pans
Front Door	<ul style="list-style-type: none"> • Guide people as to where to go • Transfer patients back and forth, for patients who were doing therapy • “Downstairs” • Take patients back and forth from wards to exercising and across other floors • Dog visit • “Portering” • Transfer patients from physio to room
Volunteer Positions/Roles without a Specific Location	<ul style="list-style-type: none"> • Usually occurs in the morning as physio is in the morning • “Helping Nurses” • Make charts (e.g. page for bloodwork, urine, etc.) for each patient that comes in • “Mail Retrieval” • Retrieving and separating mail • “Feeding Program” • Come in at mealtime and help people with their meal • “Therapy” • Transferred patients back and forth • Coordinating garage sales

Note. I combined some volunteer positions at my own discretion which were very similar in nature.

Table 6

Auxiliary Volunteer Roles Except for Fundraising

Volunteer Location	Positions and Roles
Information/Front Desk	<ul style="list-style-type: none"> • Check doctor off of list and directs them to where they need to go • Tell patients where they need to go • Tell visitors where patients are located • Sell tickets
Patient Wards	<ul style="list-style-type: none"> • “Brighten Your Day program” • “Patient Interaction” • “Friendly Visiting Program” • “Patient Visiting” • Painting ladies’ nails • “Fixing” them up
Long term Care Unit	<ul style="list-style-type: none"> • Birthday cake and singing for patients
Auxiliary Positions/Roles without a Specific Location	<ul style="list-style-type: none"> • President of the Auxiliary • Vice-President of the Auxiliary • Second-Vice President of the Auxiliary • Treasurer of the Auxiliary • Board of Auxiliary • “Friendly Visiting” • Visit all patients, not just those in palliative care • Go in and talk to patients • Put up “little things” • “Lifeline” • Install Lifeline in people’s homes • Program where people come in and sing for older adults who are “shut-ins at the hospital” • Entertain older adults (e.g. small parties) • Maintain rose garden • “Sewing Group” • “Flower ladies” • Arrange events in activities room • Help take patients to concerts • Researching what can do in community that would help older adults • Holiday celebrations (e.g. have Santa come in during Christmas, event during Easter) • Library cart

-
- Shopping cart
 - “Assisting nurses”
 - Giving patients drinking water
 - “Bursaries”
 - Award bursaries for students in the medical field
 - “Greeter”
 - Greeter “to people that come in and didn’t know where to go”
 - “Knitting Group”
 - Knit and sell goods for hospital funding
 - Knit for the gift shop
 - Knit for oncology patients
 - Victorian Tea
 - Foot care
-

Note. I combined some volunteer positions at my own discretion which were very similar in nature.

Please see Table 7 for all Auxiliary fundraising positions, roles, and activities.

Table 7

Auxiliary Fundraisers

Fundraising Locations	Positions, Roles, and Activities
Gift/Tuck Shop	<ul style="list-style-type: none"> • Make soup/coffee/lunches depending on the hospital site • Gift buyer • Stock maintenance • Book-keeping • Decorating during holiday periods • Re-organizing shop • Treasurer • Scheduling of gift shop volunteers • Creates own items to sell • Create displays • Clerk
Home	<ul style="list-style-type: none"> • Made flower arrangements • Count money that was made in the gift/tuck shop • Write up statement for money made in gift/tuck shop • Knitting clothes
Auxiliary Fundraisers without a Specific Location	<ul style="list-style-type: none"> • Lottery outlet at an Avondale store • Coffee kiosk rent • Bazaar • Selling tickets for lotteries (e.g. Nevada tickets) • Peach social • Food services • Tag Day • Walks • Wrapping Christmas presents • Tree of Lights • Bake sales • Bingo • Selling items in the mall • Having lunch/dinner in the park • Card party • Shred-It • Christmas raffle • Fashion shows

Note. I combined fundraisers stated by participants in different hospital sites, when they were very similar in nature.

Appendix A: Email Script to Older Volunteers

Dear _____,

My name is Saranjah Subramaniam and I am a graduate student at Brock University. I am sending you this Letter of Invitation on behalf of a Brock research team. The Coordinator of Volunteer Resources gave me your name and email address to contact you. We would like to invite you to participate in our research project entitled “Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario”. This study aims to explore volunteerism among older adults in community-based hospitals in [Region Name]. We are especially interested in learning about the experiences of older adults’ volunteering in hospital settings. We would also like to examine if and how volunteering helps develop social capital, which refers to the bonds, relationships, trust, and social networks that people create between each other, for older adults. We hope that this research study will raise awareness on the importance of volunteering, and its implications on how this type of activity may play a role in active aging and developing an age-friendly community.

I would be most grateful if you would kindly consider participating in this study. Your insight and experience as an expert in volunteerism in this hospital would be a great help in pursuing this research. Please read the attached Letter of Invitation and contact me at the following email if you are interested in this study: ss12kg@brocku.ca. I will contact you in a few days to follow-up, and if there is no response after a few days, I will assume that you do not wish to participate in the study.

Sincerely,

Saranjah (Sara) Subramaniam

Saranjah Subramaniam, MA Candidate
 Brock University | Department of Health Sciences
 Niagara Region | 500 Glenridge Ave. | St. Catharines, ON L2S 3A1
 Email: ss12kg@brocku.ca

CC: Dr. Miya Narushima, Associate Professor
 Brock University | Department of Health Sciences
 Niagara Region | 500 Glenridge Ave. | St. Catharines, ON L2S 3A1
 Tel: (905) 688-5550 Ext. 5149
 Email: mnarushima@brocku.ca

Appendix B: Telephone Script Initial Contact with Potential Older Volunteer

Participants

“Hello _____,

My name is Saranjah Subramaniam and I am a graduate student at Brock University. I am calling you on behalf of my research team to invite you to participate in a research project entitled Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario. I believe the Coordinator of Volunteer Resources has already contacted you regarding this research project?”

IF YES: “Ok would you like me to go over the details of the study?”

IF NO: “Alright, I was told by the Coordinator of Volunteer Resources that you are interested in participating in this study. If you have some time, would you like me to go over the details of the study so that you can decide whether you want to participate?”

IF YES: Go over details of study using Letter of Invitation for Older Adults

IF NO: “Would you like to go over it at another time which is convenient for you?”

IF YES: Schedule another time to talk.

IF NO: “Ok, thank you. Good-bye.”

[Letter of Invitation Reference Script to Review with the Participants]:

“Alright so just to reiterate, the purpose of this study is to explore volunteerism among older adults in community-based hospitals. We are especially interested in learning about the experiences of older adults’ volunteering as well as how volunteering helps develop social capital (ie. the bonds, relationships, trust, and social networks that people create between each other). Since you are the expert of volunteering we would be most grateful if you could share your experiences and insights with us.

Should you kindly decide to participate in this study, myself, the student principal investigator, will come to see you to conduct a face-to-face individual interview at your convenience. The interview will last about 45-60 minutes, and will be audio-recorded in order to transcribe afterwards.

Your participation in this study is voluntary, which involves no monetary incentive. You can withdraw from the study at any time. We are planning to complete this research study by the end of August 2015. We will send you a summary report at the completion of the study.

It is our sincere hope that the findings from this study will raise awareness on the importance of volunteering, and its implications on how this type of activity may play a role in active aging and developing an age-friendly community.

This study has been reviewed and received ethics clearance through Brock University’s

Research Ethics Board [14-028], and the [Region Name] Research Ethics Board [2014-12-002].”

“Do you have any questions about the study?”

IF YES: Answer the questions.

IF NO: “If you would like to read the Letter of Invitation, I can gladly mail it to you. Please let me know what address I should mail it to?”

“I will follow up with a phone call four days from now to confirm your participation and to schedule an interview. At that point I will send you the informed consent form and a copy of the interview guide for you to go over. On behalf the research team, I would like to thank you again for taking the time to consider being part of this study. Good-bye.”



Community Hospital Network Logo

Appendix C: Letter of Invitation to Older Volunteers

January __, 2015

Title of Study: Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario

Dear _____,

You are being invited to participate in a research project conducted by a team of Brock researchers (Dr. Miya Narushima & her graduate student Saranjah Subramaniam), entitled Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario.

The purpose of this study is to explore volunteerism among older adults in community-based hospitals in [Region Name]. We are especially interested in learning about the experiences of older adults' volunteering as well as how volunteering helps develop social capital (i.e. the bonds, relationships, trust, and social networks that people create between each other). Since you are the expert of volunteering we would be most grateful if you could share your experiences and insights with us.

Should you kindly decide to participate in this study, a student investigator, Saranjah Subramaniam, will come to see you to conduct a face-to-face individual interview at your convenience. The interview will last about 45-60 minutes, and will be audio-recorded in order to transcribe afterwards.

Your participation in this study is voluntary, which involves no monetary incentive. You can withdraw from the study at any time. We are planning to complete this research study by the end of August 2015. We will send you a summary report at the completion of the study.

It is our sincere hope that the findings from this study will raise awareness on the importance of volunteering, and its implications on how this type of activity may play a role in active aging and developing an age-friendly community.

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board [14-028], and the [Region Name] Research Ethics Board [2014-12-002]. If you have any questions about your rights as a research participant, please contact either the Brock University Research Ethics Officer (905-688-5550 ext. 3035, reb@brocku.ca), or the [Region Name] Research Ethics Board [number] ext. [number], [\[email\]](#).

Thank you so much for your kind consideration. We look forward to hearing from you soon.

Sincerely,

Principal Student Investigator:

Saranjah Subramaniam
MA candidate
Department of Health Sciences
Brock University
Email: ss12kg@brocku.ca

Principal Investigator:

Dr. Miya Narushima
Associate Professor
Department of Health Sciences
Brock University
Email: mnaurshima@brocku.ca

Appendix D: Telephone Script Follow-up to Initial Email/Phone Call to Older

Adults

(For Arranging an Interview)

“Hello _____,

My name is Saranjah Subramaniam and I am a graduate student at Brock University. I am calling you to follow up on an email/phone call that Dr. Narushima and I sent you four days ago regarding your participation in a research project to explore volunteerism among older adults in community-based hospitals in [Region Name]. Did you receive this email/phone call?”

IF NO: “Ok would you like me to send you the Letter of Invitation again?”

IF NO: “Thank you, good-bye.”

IF YES: “Ok, can I confirm your email/ mailing address? I will send it again to you shortly. Please take a look through it and I will call you in a week to follow up on whether you would like to participate.”

IF YES: “Ok, have you thought about whether you want to be a participant in the study?”

“Thank you, I appreciate your interest in taking part in our study. Did you have any questions after taking a look at the attached Letter of Invitation?”

IF NO: “Great. Would you like to schedule an interview for the study?”

IF YES: Answer any questions that they have.

“I have some forms that I want you to take a look at before the scheduled interview. These include the Informed Consent form, and the interview guide. Please let me know how you would like me to send them.”

“On behalf the research team, I would like to thank you again for taking the time to consider being part of this study. Good-bye.”



Community Hospital
Network Logo

Appendix E: Informed Consent Form for Older Volunteers

Date: ____

Project Title: Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario

Principal Student Investigator:

Saranjah Subramaniam
MA candidate
Department of Health Sciences
Brock University
Email: ss12kg@brocku.ca

Principal Investigator:

Dr. Miya Narushima
Associate Professor
Department of Health Sciences
Brock University
Email: mnaurshima@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to explore volunteerism among older adults in community-based hospitals in [Region Name]. We are especially interested in learning about the experiences of older adults' volunteering as well as how volunteering helps develop social capital (i.e. the bonds, relationships, trust, and social networks that people create between each other). We will be interviewing both older volunteers and hospital staff as part of this project.

WHAT'S INVOLVED

You will be asked to participate in an individual face-to-face interview session with the student investigator (Saranjah Subramaniam). Your interview will be audio recorded with your permission, and transcribed later. The interview will last approximately 45 to 60 minutes. The questions in the interview will focus around these key areas: (a) motivations and barriers to volunteering for older adults; (b) benefits and challenges of having older volunteers; (c) how volunteer management strategies such as those used for recruitment and retention are seen by participants; (d) development of social capital as a result of volunteering.

In addition, you will have the opportunity to read through the transcription of your interview, which will be emailed to you approximately 2 weeks after conduction of the interview. Through this member checking, you will be able to confirm the accuracy of the transcript before it is used for data analysis. Member checking should take approximately 2 to 3 hours to complete. There will be a one week timeline for you to go over the transcript and contact us via phone or email with any changes or clarifications if they are

needed. If we do not hear from you after this one week, we will assume that the transcript is fine the way it is, and they will proceed with data analysis.

POTENTIAL BENEFITS AND RISKS

While you will not receive any compensation for participating in this project, there may be some benefits to your participation. For example, you may benefit from knowing that you will be contributing information that may help to increase the knowledge on older adults' volunteering and its implications for the development of active aging and an age-friendly community.

There may be minimal risks associated with participation in this research study. For example, you may feel pressured to participate or to talk about positive characteristics of the volunteers and the organization as you were notified of this study by the Coordinator of Volunteer Resources, or you may worry about what other volunteers and your boss may say about the findings of the research. In order to minimize this pressure, we first encourage you to contact us if at any point, you feel that you do not want to take part in the study anymore. In addition, any personal identifiers or specific descriptors in the reporting of the results will be removed or replaced with pseudonyms or general descriptors to protect your identity. Only the principal student investigator and principal investigator will be in contact with you after you provide your contact information, in order to protect your identity.

CONFIDENTIALITY

The information you provide will be kept confidential through the methods discussed above. Your name and other personal identifiers will not appear in any final reports and presentations of this study. However, with your permission, anonymous quotations will be used. Shortly after the interview has been completed, we will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish.

Access to data collected during this study (e.g., audio recordings and interview transcripts) will be restricted to the student investigator (Saranjah Subramaniam) and the principal investigator (Dr. Miya Narushima). Data will be stored in both the student investigator's and the principal investigator's computers, or in a locked cabinet in the principal investigator's office. These computers will be password-protected and will only be accessed by the student investigator and the principal investigator. Data will be kept for approximately 3 years after which time the data will be destroyed, and hard copies of the transcript will be shredded and put in a confidential disposal bin in the principal investigator's department.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. There is no monetary incentive. If you wish, you may decline to answer any questions or participate in any component of the study.

Further, you may decide to withdraw from this study at any time and may do so without penalty. Withdrawing from this study will in no way affect your relationships with the hospital staff and other volunteers in the future.

If you decide to withdraw from the study, you can contact either the principal student investigator or the principal investigator to do so. All of your data (e.g. transcript of the interview, contact information) will be destroyed, unless you withdraw 2 weeks after your final confirmation on the accuracy of the final transcript (member checking). At this point, the data cannot be destroyed as it will be de-identified in data analysis and we cannot differentiate it from the data from other participants.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Final results of this study will be available in August of 2015. A summary report of the findings will be mailed to you by the student investigator.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Saranjah Subramaniam and Dr. Miya Narushima using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [14-028], and the [Region Name] Research Ethics Board [2014-12-002]. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca, or the [Region Name] Research Ethics Board at [number] Ext. [number], [\[email\]](#).

Thank you for your assistance in this project. Please keep a copy of this form for your records.

Name: Saranjah Subramaniam Dr. Miya Narushima

Signature: _____ Date: _____

Signature: _____ Date: _____

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Letter of Invitation and Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

Appendix F: Older Volunteer Interview Guide

Introduction

SS: *Thank you for taking the time to participate in my study. I would like to tell you a little about my research project before we begin with the questions. Currently I am a graduate student at Brock University and am interested in learning about older adults who volunteer in hospitals in [Region Name]. Specifically I want to examine the experiences of these older volunteers and the development of social capital in hospital settings. I would like to hear about your own experiences and insights as well as insights about older adult volunteers over the age of 65, here in this hospital. Through this interview we will cover the following four areas: (a) motivations and barriers to volunteering for older adults; (b) benefits and challenges of having older volunteers; (c) how management strategies such as those used for recruitment and retention are seen by participants; (d) development of social capital as a result of volunteering. Throughout the interview, when I talk about older volunteers, I will be referring only to individuals aged 65 and over. I want you to know that this research project, including this interview, is completely voluntary and you can withdraw at any point in time without any penalties. In addition, you are not obligated to answer any question that may make you feel uncomfortable. Do you have any questions or comments before we begin? Ok then let's begin.*

Section 1: Background Information about the Older Volunteer

1. Could you tell me a bit about yourself in relation to your volunteer position in this hospital (e.g., your role, how long you have been volunteering here, and your interaction with older volunteers)?

SS: *Thank you. Ok, next I would like to move into the questions about the current conditions of older adult volunteers.*

Section 2: Older Volunteers

SS: *In regards to older volunteers:*

2. What motivates you to volunteer in the hospital? Do you think that fellow older volunteers have similar motivations as yours?
3. What do you feel are factors that can pressure an older adult to engage in volunteering (e.g. negative view from society, productive/active aging)? Have these factors had an influence on your own reason to engage in volunteering?
4. How do you feel about volunteering in hospitals, in relation to other volunteer

positions that you may have taken part in? Is volunteering in hospitals unique from other positions?

5. What were the barriers that may have hindered you from volunteering in this hospital? Do you think that fellow older volunteers had similar barriers as yours?
 6. What benefits have you had as a result of volunteering in this hospital? Do you think that fellow older volunteers have similar benefits to yours? What benefits do hospitals receive as a result of having older volunteers?
 7. How did you find this volunteer position? What recruitment strategies do you know of that are used to recruit older adults to volunteer in this hospital? Are these strategies different than the ones used to recruit other age groups? If so, why?
 8. Have you had any training by the hospital to become a volunteer? If so, can you explain a bit more about these procedures? Do you still have training from time to time? What training strategies are used to train older adult volunteers in this hospital? Are these strategies different than the ones used to train other age groups? If so, why?
 9. I've heard that to retain trained volunteers is one of the challenges for organizations. How about in this hospital? Do you feel the same way in this hospital? If so, why?
 10. Do you know if the hospital uses any specific strategies to retain their volunteers? If so, what are they? What is your opinion about the effectiveness of the strategy?
- SS:** *Thank you for sharing this with me. The next series of questions will be about the development of social capital for older adults as a result of volunteering.*

Section 3: Development of Social Capital

SS: *“Social capital” refers to the bonds, relationships, trust, and social networks that people create between each other. In particular, my research will focus on the social capital that is created by, with, and for older adult volunteers in this hospital.*

11. What type of social relationships have you created with other volunteers through your volunteering here? Do you think that other older volunteers have had a similar experience to yours?
12. What type of social relationships have you had with hospital staff or management in this hospital? Do you think other older volunteers had similar social relationships?

13. What type of social relationships do you have with patients and their families, or other people from the community? Do you think that other older volunteers have created these types of social relationships?
14. What factors in this hospital do you think facilitate the development of these social relationships and networks for older volunteers? Are there are factors which hinder the development of these social relationships for older volunteers?
15. How do you feel these social relationships influence your life? What about for other older volunteers?
16. How does the development of these social relationships affect hospitals? How does it affect communities?

Conclusion

SS: *Thank you again for taking the time to participate in this interview! The information you have shared with me will be very useful. Do you have any additional questions or comments that you would like to add? I will mail you a copy of the transcript in approximately two weeks to check for accuracy of this conversation, as well as give you the opportunity to add or change anything that was said. There will be a one week timeline for you to go over the transcript and contact us via phone or email with any changes or clarifications if they are needed. If we do not hear from you after this one week, we will assume that the transcript is fine the way it is, and they will proceed with data analysis. Please feel free to contact me at any time if you have any questions or concerns.*

Appendix G: Email Script to Key Informants

Dear ____ and _____,

Thank you again for collaborating with me on the research project titled “Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario”. As it has been a few months, I wanted to send this email to give you an update on the progress of the research as well as the updated timeline. I am completing the findings, and through discussions with my supervisor (Dr. Narushima), have decided to modify the research objectives, to solely focus on the perspectives of older volunteers, rather than focusing on the perspectives of both older volunteers and hospital staff.

As such, I would like to invite both of you to take part in an interview with myself, in order to just confirm certain aspects about the volunteers’ situations (e.g., the number of total volunteers, recruitment and training strategies, etc.). As both of you are the experts in [Community Hospital Network Name] volunteers, I wanted to ask for your opinions and thoughts on the data that has been found so far.

In order to confirm these aspects, I would like to set up a face-to-face interview in August. The interview would be used to verify and confirm the findings of what we found from the interviews with older volunteers. If both of you are available to participate in it, that would be wonderful. If only one of you can participate on behalf of both individuals, then I can meet whomever is available.

Participation in this study is voluntary, and you should not feel obligated to participate in the interviews given that you are collaborators of this project. Please see the attached Letter of Invitation which contains details regarding the purpose and conduction of the interview, and contact me at this email address if you are interested in participating: ss12kg@brocku.ca. Thank you for your time.

Sincerely,

Saranjah Subramaniam, MA Candidate
 Brock University | Department of Health Sciences
 Niagara Region | 500 Glenridge Ave. | St. Catharines, ON L2S 3A1
 Email: ss12kg@brocku.ca

CC: Dr. Miya Narushima, Associate Professor
 Brock University | Department of Health Sciences
 Niagara Region | 500 Glenridge Ave. | St. Catharines, ON L2S 3A1
 Tel: (905) 688-5550 Ext. 5149
 Email: mnarushima@brocku.ca

Appendix H: Letter of Invitation for Key Informants

August ____, 2015

Title of Study: Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario

Dear _____,

You are being invited to participate in a research project entitled Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario, conducted by a team of Brock researchers (Dr. Miya Narushima & her graduate student Saranjah Subramaniam).

The purpose of this study is to explore volunteerism among older adults in community-based hospitals. We are especially interested in learning about the experiences of older adults' volunteering as well as how volunteering helps develop social capital (i.e. the bonds, relationships, trust, and social networks that people create between each other). Since you are the expert of volunteering, we would like to interview you in order to verify and confirm the findings of what we found from the interviews with older volunteers.

Should you kindly decide to participate in this study, a student investigator, Saranjah Subramaniam, will come to see you to conduct a face-to-face individual or group interview (with another volunteer coordinator) in your preferred style at your convenience. The interview will last approximately an hour for one person, and 1.5 to 2 hours long if it is a group interview. It will be audio-recorded in order to type a summary of key points onto a Word document. In addition, we would be grateful if you could share any documents that might be helpful for us to understand your volunteer program (e.g. statistics or trends of volunteerism in regards to both older volunteers and volunteers in general).

Your participation in this study is voluntary, which involves no monetary incentive. You can skip any questions that you are not comfortable with in the interview, and withdraw from the study at any time. We are planning to complete this research study by the end of December 2015. We will send you a summary report at the completion of the study.

It is our sincere hope that the findings from this study will raise awareness on the importance of volunteering, its implications on how this type of activity may play a role in active aging and developing an age-friendly community.

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board [14-028], and the [Region Name] Research Ethics Board [2014-12-002]. If you have any questions about your rights as a research participant, please contact either the Brock University Research Ethics Officer (905-688-5550 ext. 3035, reb@brocku.ca), or the [Region Name] Research Ethics Board [number]ext. [number], [email].

Thank you so much for your kind consideration. We look forward to hearing from you soon.

Sincerely,

Principal Student Investigator:

Saranjah Subramaniam
MA candidate
Department of Health Sciences
Brock University
Email: ss12kg@brocku.ca

Principal Investigator:

Dr. Miya Narushima
Associate Professor
Department of Health Sciences
Brock University
Email: mnaurshima@brocku.ca



Community Hospital Network Logo

Appendix I: Informed Consent Form for Key Informants

Date: _____

Project Title: Volunteering and Social Capital: A Case Study of Older Hospital Volunteers in Southern Ontario

Principal Student Investigator:

Saranjah Subramaniam
 MA candidate
 Department of Health Sciences
 Brock University
 Email: ss12kg@brocku.ca

Principal Investigator:

Dr. Miya Narushima
 Associate Professor
 Department of Health Sciences
 Brock University
 Email: mnaurshima@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to explore volunteerism among older adults in [Region Name] community-based hospitals. We are especially interested in learning about the experiences of older adults' volunteering as well as how volunteering helps develop social capital (i.e. the bonds, relationships, trust, and social networks that people create between each other). We just finished interviewing with older volunteers in the [Community Hospital Network Name]. Now we would like to interview you in order to clarify and/or confirm some points and questions raised from what we found from the interviews with older volunteers.

WHAT'S INVOLVED

You will be asked to participate in a face-to-face individual interview or a group interview (with another volunteer coordinator) with the student investigator (Saranjah Subramaniam). Your interview will be audio recorded with your permission, and a summary of key points will be typed onto a Word document afterwards. The interview will last approximately an hour for one person, and 1.5 to 2 hours long if it is a group interview.

The researcher will also ask you to provide any additional internal documents on both older volunteers and volunteers in general in the hospitals if possible. For example, the number of volunteers, changes in volunteers over the past few years, number of hours committed by volunteers, and the types of roles volunteers are assigned. These documents will help us grasp an overview of the volunteer demographics in your organization, and be used to help provide a general background description of the case of community-based hospitals in [Region Name]. We request that any personal identifiers in these documents be removed beforehand.

In addition, you will have the opportunity to read through the typed Word document of the summary of key points of your interview, which will be emailed to you approximately 3-4 days after conduction of the interview. Through this member checking, you will be able to confirm the accuracy of the document or make any changes before it is used for data analysis. Member checking should take approximately half an hour to complete. There will be a one week timeline for you to go over the document and contact us via phone or email with any changes or clarifications if they are needed. If we do not hear from you after this one week, we will assume that the document is fine the way it is, and will proceed with data analysis.

POTENTIAL BENEFITS AND RISKS

While you will not receive any compensation for participating in this project, there may be some benefits to your participation. For example, you may benefit from knowing that you will be contributing information that may help to increase the knowledge on older adults' volunteer experiences and its implications for the development of active aging and an age-friendly community.

There may be minimal risks associated with participation in this research study. For example, you may feel pressured to talk about positive characteristics of the volunteers and the organization, or you may be worried about what your colleagues or boss may say about the findings of the report. In order to minimize these pressures and risks, we will use the term "key informants" and/or "hospital staff" to refer to you in our final reports or presentation of this study. We will use findings from this key informant interviews only as background information. The information obtained from this interview will help the researchers to finalize the themes for their findings. We may include some figures (e.g. volunteer statistics) that will be obtained as internal documents (if any) into the case description section to provide the background context of the [Community Hospital Network Name]. However, we won't directly include any of your accounts as your opinions or the [Community Hospital Network Name] perspectives. We can acknowledge you as collaborators of the research project, rather than as participants, and thus include your names on any posters or presentations, only if you wish to do so.

CONFIDENTIALITY

The information you provide will be kept confidential. Access to data collected during this study (e.g., audio recordings and typed documents) will be restricted to the student investigator (Saranjah Subramaniam) and her thesis supervisor (Dr. Miya Narushima). Data will be stored in both the student investigator's and the principal investigator's computers, or in a locked cabinet in the principal investigator's office and the student principle investigator's home. The computers will be password-protected and will only be accessed by the student investigator and the principal investigator. Data will be kept for 3 years after which time the data will be destroyed, and hard copies of the typed document will be shredded and put in a confidential disposal bin in the principal investigator's department.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. There is no monetary incentive. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without penalty. Withdrawing from this study will in no way affect your relationships with the other hospital staff and volunteers, and the researchers of this study.

If you decide to withdraw from the study, you can contact either the principal student investigator or the principal investigator to do so. All of your data (e.g. typed document of the interview, contact information) will be destroyed, unless you withdraw 2 weeks after your final confirmation on the accuracy of the final typed document (member checking). At this point, the data cannot be destroyed as it will be de-identified in data analysis and we cannot differentiate it from the data from other participants.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Final results of this study will be available in December of 2015. A summary report of the study will be mailed to you by the student investigator.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Saranjah Subramaniam and Dr. Miya Narushima using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [14-028], and the [Region Name] Research Ethics Board [2014-12-002]. If you have any comments or concerns about your rights as a research participant, please contact either the Brock Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca, or the [Region Name] Research Ethics Board at [number] Ext. [number], [\[email\]](#).

Thank you for your assistance in this project. Please keep a copy of this form for your records.

Name: Saranjah Subramaniam (MA candidate) Dr. Miya Narushima

Signature: _____ Date: _____

Signature: _____ Date: _____

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Letter of Invitation and Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

Appendix J: Key Informant Interview Guide

Introduction

SS: *Thank you for taking the time to participate in my study. I would like to update you a little about my research project before we begin with the questions. Our interviews with the older volunteers went very well and we gathered very rich stories from these older adults regarding their volunteer experiences – much more than we had expected! We have analyzed the data from the older adult volunteers' interviews, and have decided to change the purpose of the study to just focus on the perspectives of older adult volunteers, rather than compare the perspectives of older volunteers with the perspectives of hospital staff. This is due to the abundance of rich data that we received from older volunteers, as well as the deadlines that I have for completing my MA thesis. Therefore the purpose of the interviews now is mainly for verification or confirmation of what we found in the analysis of data from the older volunteers' interviews. Through this interview we will cover the following six areas about older volunteers: (a) volunteer trends in the hospitals; (b) management strategies such as recruitment, training, and retention; (c) auxiliary volunteers; (d) uniqueness of hospital volunteering and barriers; and (e) hospital condition and change. Throughout the interview, when I talk about older volunteers, I will be referring to individuals aged 65 and over. I want you to know that this research project, including this interview, is completely voluntary and you can withdraw at any point in time without any penalties. In addition, you are not obligated to answer any question that may make you feel uncomfortable. Do you have any questions before we begin? Ok then let's begin.*

Background Information about the Hospital Staff

1. *I understand that your role in the [Community Hospital Network Name] is a Volunteer Coordinator. Could you tell me a bit about yourself (e.g., how long you have been working here, which hospitals you are in charge of, what your main roles are, and your interaction with older volunteers, etc.)?*

SS: *Thank you for sharing this with me. The first series of questions will be about volunteer trends in the hospital. All of the older volunteers who participated in my interviews were female, and most were relatively older. So I'm wondering about the typical demographic characteristics of the [Community Hospital Network Name] volunteers.*

Volunteer Trends

2. *How does the current demographic of volunteers in the [Community Hospital Network Name] look like?*

- a. (Probe): How many volunteers are there in total? How many volunteers are there for each hospital site approximately?
 - b. (Probe): How many older adults are volunteering at the [Community Hospital Network Name]? How many older adults approximately are volunteering at each hospital site?
 - c. (Probe): Compared with younger volunteers, does older volunteers consist of a larger portion of the [Community Hospital Network Name] volunteers?
 - d. (Probe): Have these numbers changed in any way from the past?
- 3. *In the data I collected, I found that older volunteers stated the “need” or “demand” for hospitals to have volunteers. How do you see the demand for volunteers in the [Community Hospital Network Name]?*
 - a. (Probe): Is there a difference in the demand for older volunteers and younger volunteers?
 - b. (Probe): Does each hospital site have different demand for volunteers?
 - c. (Probe): What changes (if any) have you seen in volunteer demand over the years?
- 4. *One of the interesting findings from my interview with older volunteers is that there are two different types of volunteers in each hospital – “pink coats” and “yellow coats”, which I did not know of. “Pink coats” refer, according to our older volunteer participants, to auxiliary volunteers, whereas “yellow coats” refer to volunteers that are not with the auxiliary. Is this true?*
 - a. (Probe): What are the major differences between pink coats and yellow coats volunteers? (e.g., tasks, locations, roles, power, etc.)
 - b. (Probe): What do you think will be the future demand of volunteers in the hospital in terms of pink and yellow coat volunteers?
 - c. *Some older volunteers suggested that there may not be a need for volunteers outside of fundraising purposes. Do you think there will be a future demand for volunteers? For which jobs?*
- 5. *Most older volunteers told me that they see themselves being needed by their hospitals, making an important contribution in helping staff and patients and their families. Do you agree with that?*
 - a. (Probe) Are there any benefits of having older volunteers? Is there anything unique about older volunteers, compared to other volunteers?

SS: *Thank you. I would like to now move into the questions about the recruitment and*

training of volunteers.

Recruitment, Training, and Retention

6. *The older volunteers do not seem to be to know the specifics regarding the recruitment and training of volunteers, so I was hoping that you would clarify some aspects of both for me.* What are your recruitment strategies for volunteers? How long does it usually take? Is the process different for older adults?
 - a. How about for pink versus yellow coats? *It seems from the interviews that the recruitment process is the same for both.* Are there differences in recruitment strategies between potential pink coats and yellow coats?
7. How about role assignment? *Older volunteers said that they did have a preference for positions in the hospital.* Do volunteers have preference in the positions that they apply to when they first start volunteering?
8. Are there any rules and regulations for volunteer recruitment? *From what I understand, older adults or the auxiliary cannot advertise positions other than through word-of-mouth.* Why is this the case?
9. *It seems that some of the challenges brought up in regards to recruitment involve the required procedures that need to be followed (e.g. TB test), as well as a lack of initial participants.* What do you think are the challenges in regards to recruitment of older adult volunteers?
10. *According to the older volunteers, training usually consists of: 1) general orientation, 2) on-the-job type of training, and 3) ongoing education.* Is this true? How are older volunteers normally trained to learn about their specific roles?
 - a. (Probe): Is most of the training done by other volunteers rather than by volunteer management?
 - b. (Probe): Are there differences in training strategies between pink coats and yellow coats?
11. What procedures are there in place to encourage volunteers to stay longer?
 - a. Is there an issue with retaining older volunteers?
12. Do you find that there are complaints from volunteers about hospital management (e.g. lack of acknowledgment of volunteers' suggestions for improvement, services hospitals provide to patients)?

SS: *Thank you for this information! The next set of questions will be about auxiliary volunteers in particular. In previous section, you told me about the difference between pink coats and yellow coats volunteers, but I would like to know more about pink coat volunteers, since many of my participants were auxiliary members.*

Auxiliary

13. *I've heard that the Auxiliary at the [hospital name] is the oldest one in Canada. Can you tell me a bit about auxiliary's profile for the 6 hospital sites? What are the demographic characteristics of auxiliary volunteers? Is there a difference compared to yellow coat volunteers? (e.g. all female, retired, older, etc.)*

- a. (Probe): *According to the older volunteers, it seems that the auxiliaries have special ownership / more power in the hospital compared with yellow coat volunteers. Is it true? What ownership does the auxiliary have of hospital-related facilities? Is there anything else in the hospital that they are in charge of (e.g. Auxiliary roles)?*
- b. *Is there anything unique about the hospital's auxiliary from the management perspective? For example, in regards to recognition of volunteers, coordinated events, etc.?*
- c. *In terms of the numbers, are auxiliaries growing? Or do you think they will be amalgamated into yellow coat volunteers eventually? What do you think are the future prospects of pink coats and yellow coats?*

SS: *Thank you. I would like to now move into the questions about the development of social capital.*

Social Capital

SS: *"Social capital" refers to the bonds, relationships, trust, and social networks that people create between each other. In particular, my research will focus on the social capital that is created by, with, and for older adult volunteers in hospitals.*

14. *It seems that there are several factors which facilitate or hinder the development of connections or relations between older volunteers, and other groups of individuals. For example, relations between older volunteers and other older volunteers, seemed to be hindered by the rules in effect while they volunteered (e.g. only one volunteer per shift). What do you think are the factors that facilitate or hinder the development of social capital between older adult volunteers?*

- a. Are these the same sort of factors which affect relationships (i.e. social capital) between older volunteers and patients/family/visitors? *For example, we found that location played a large role in the lack of connections developed between older volunteers and patients/family/visitors.*
- b. Are these the same sort of factors which affect relationships (i.e. social capital) between older volunteers and staff/management?
- c. Are these the same sort of factors which affect relationships (i.e. social capital) between older volunteers and the people in the community?

SS: *Thank you for your responses. The next section will focus briefly upon the uniqueness of hospital volunteers as well as barriers.*

Uniqueness of Hospital Volunteering and Barriers

- 15. *Older volunteers said that hospital volunteering was unique compared to volunteering in other locations (e.g., church).* What do you think make hospitals a unique place to volunteer?
- 16. *I found that some volunteers had told stories of friends who were not able to volunteer due to difficulties applying for the volunteer position.* What do you think are barriers which may stop older adults from becoming volunteers in the hospital? (e.g. hospital closures, closure of facilities, a decrease in open hours for the gift shop).

SS: *Thank you. Finally, I would like to move into the questions about hospitals' current conditions and change.*

Hospital Condition and Change

One unexpected finding that I had from my interviews with older volunteers is their strong affection, pride, and commitment to their own "community" hospitals....saying "this is my hospital", or "we are very proud of our hospital", etc.

- 17. Are there any special characteristics about [Region Name] that make it unique from other locations? What about the community where each hospital is located?
 - a. (Probe) Can you explain to me a bit the differences and similarities among the six hospitals in the [Community Hospital Network Name]? What is the current condition of the hospitals (e.g. in terms of size of the hospital, is it an urgent care centre/full service hospital, volume of patients)?
 - i. How do you think each hospital's conditions affect older volunteers?
- 18. *According to the older volunteers' stories, there are ongoing system-level changes in the [Community Hospital Network Name] which are affecting the hospitals. For*

example, I found that one of the hospitals was closing, and a few others have closed facilities such as their cafeterias. Can you tell me about changes that have occurred in the [Community Hospital Network Name] in general, or in each of the 6 hospital sites (e.g. closures, expansions)?

- a. (Probe): How do you see the effects of these changes on older volunteers? Any positive or negative effects? (e.g. in regards to making connections at their volunteer location)? How about on patients? The surrounding community?
- b. (Probe): *I've heard that there are several places where older adults can volunteer within the hospitals.* What are some of the more popular places where people volunteered? Were there any changes which affected these locations where older adults volunteered?
 - i. How do you see the effects of these changes on older volunteers? Any positive or negative effects? (e.g. in regards to making connections at their volunteer location)?

19. Have there been any hospital procedures/organizational changes as a result of volunteers enacting change?

Conclusion

SS: *Thank you again for taking the time to participate in this interview! The information you have shared with me will be very useful. Do you have any additional questions or comments that you would like to add? I will send you a summary of this interview in approximately 3 to 4 days to check for accuracy of this conversation, as well as give you the opportunity to add or change anything that was said. There will be a one week timeline for you to go over the summary and contact us via phone or email with any changes or clarifications if they are needed. If we do not hear from you after this one week, we will assume that the summarized points are fine the way they are, and will proceed with data analysis. Please feel free to contact me at any time if you have any questions or concerns.*